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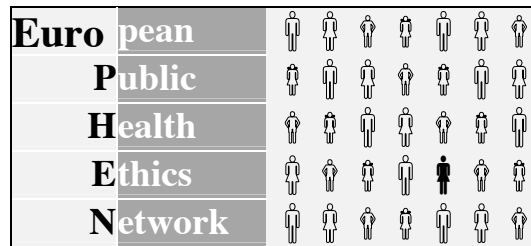


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Public policies, law and bioethics: a framework for producing public health policy across the European Union

EuroPHEN

(European Public Health Ethics Network)

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Abstract

Unlike the duties of clinicians to patients, professional standards for ethical practice are not well defined in public health. This is mainly due to public health practice having to reconcile tensions between public and private interest(s). This involves at times being paternalistic, while recognising the importance of privacy and autonomy, and at the same time balancing the interests of some against those of others. The Public Health specialist operates at the macro level, frequently having to infer the wishes and needs of individuals that make up a population and may have to make decisions where the interests of people conflict. This is problematic when devising policy for small populations; however, it becomes even more difficult when there is responsibility for many communities or nation states. Under the Treaty on European Union, the European Commission was given a competence in public health. Different cultures will give different moral weight to protecting individual interests versus action for collective benefit. However, even subtle differences in moral preferences may cause problems in deriving public health policy within the European Union. Understanding the extent to which different communities perceive issues such as social cohesion by facilitating cultural dialogues will be vital if European institutions are to work towards new forms of citizenship.

The aim of EuroPHEN was to derive a framework for producing common approaches to public health policy across Europe. Little work has been done on integrating ethical analysis with empirical research, especially on trade-offs between private and public interests. The disciplines of philosophy and public policy have been weakly connected. Much of the thinking on public health ethics has hitherto been conducted in the United States of America, and an ethical framework for public health within Europe would need to reflect the greater respect for values such as solidarity and integrity which are more highly valued in Europe. Towards this aim EuroPHEN compared the organisation of public health structures and public policy responses to selected public health problems in Member States to examine how public policy in different countries weighs competing claims of private and public interest. Ethical analysis was performed of tensions between the private and public interest in the context of various ethical theories, principles and traditions. During autumn 2003, 96 focus groups were held across 16 European Union Member States exploring public attitudes and values to public versus private interests. The groups were constructed to allow examination of differences in attitudes between countries and demographic groups (age, gender, smoking status, educational level and parental and marital status). Focus group participants discussed issues such as attitudes to community; funding of public services; rights and responsibilities of citizens; rules and regulations; compulsory car seat belts; policies to reduce tobacco consumption; Not-In-My-Back-Yard arguments; banning of smacking of children; legalising cannabis and parental choice with regards to immunisation. This project proposes a preliminary framework and stresses that a European policy of Public Health will have to adopt a complex, pluralistic and dynamic goal structure, capable of accommodating variations in what specific goals should be prioritised in the specific socio-economic settings of individual countries.

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Executive Summary

Background

Definition of Public Health

In 1952 the WHO proposed a definition of public health which encapsulated a wide variety of state activities such as preventing epidemics, increasing sanitation, safeguarding food and water as well as monitoring the health status of the population. As Public Health has evolved in recent years the WHO's definition has been criticised, particularly on the basis that it fails to capture the breadth and aims of public health action which extend beyond improving health *per se*. A number of alternative definitions have been proposed based on the shift away from viewing health simply as an absence of illness or prolonging life towards viewing health in terms of wellbeing.

While traditional Public Health emphasised the role of the state and public organisations more recent definitions seek to emphasise collective responsibility for health and a concern for the underlying socio-economic and wider determinants of health. In this regard Public Health is concerned with issues of equity in the distribution of health in a population and the creation of societal conditions to allow healthy choices to be made if desired. This involves the organised efforts and informed choices of society, organisations, public and private, communities and individuals. As a result Public Health is now viewed as *“the science and art of preventing disease, prolonging life and promoting health through organised efforts of society”*. Public health practice is characterised by: its emphasis on collective responsibility for health and the prime role of the state in protecting and promoting the public's health; a focus on whole populations; an emphasis on prevention, especially the population strategy for primary prevention; a concern for the underlying socio-economic determinants of health and disease, as well as the more proximal risk factors; a partnership with the populations served.

Tensions between private and public interest

Public health practice has to reconcile tensions between public and private interest, at times being paternalistic, while recognising the importance of privacy and autonomy, and at the same time balancing the interests of some against those of others, and/or society as a whole. In practice, one or more tensions may arise between private and public interest within the development and practice of public policy. For example what the individual thinks is in his or her best interests may:

- Be contrary to what others think is in the individual's best interests. Such policies would be paternalistic. Children are a special case where parents and others may have conflicting views of the child's best interests;
- Conflict with the best interests of one or more other identifiable individuals. Here public policy has an adjudication role and may consider desert and duties of care;
- Conflict with general societal interest i.e. interests of one or more individuals who are not identifiable or yet to be born. For example, arguments of justice might require a maximisation of return from scarce societal resources.

The duties of clinicians to patients are well established. In contrast, professional standards for ethical practice are not well defined in public health, because a public health specialist

operates at the macro level, in some cases far removed from the context of health care, and frequently has to infer the wishes and needs of individuals that make up a population and may have to make decisions where the interests of people conflict. This is problematic when devising policy for small populations; however, it becomes even more difficult when there is responsibility for many communities or nation states.

Rationale

Under the Treaty on European Union, the European Commission was given a competence in public health. Different cultures will give different moral weight to protecting individual interests versus action for collective benefit. There is likely to be scope for variance with expansion of the European Union. However, even subtle differences in moral preferences may cause problems in deriving public health policy within the European Union. Understanding the extent to which different communities perceive issues such as social cohesion by facilitating cultural dialogues will be vital if European institutions are to work towards new forms of citizenship.

Normative Ethics

The central question of moral philosophy, is *how should one live?* *Normative ethics* provides substantive proposals as to how live, how to act, what sort of person one should be. In particular, it attempts to provide a moral framework governing these principles, in terms of what is right and wrong and in turn to specify associated rights and duties etc.. Since such basic moral principles will probably be stated in more general terms, it may not be clear as what should be done in a particular case, especially in morally complex situations. This is more likely within a normative framework derived from several fundamental principles which conflict or appear to conflict. It may even be difficult to assess how one fundamental principle should be applied in a particularly controversial issue. *Applied ethics* is therefore the branch of moral philosophy that seeks to apply the general principles of *normative ethics* to such complex problems.

The EuroPHEN project is primarily concerned with *normative ethics*. It is *applied* in the sense of application to the field of Public Health. But it aims to ask address the question *How should one practice as a Public Health Professional?* (as opposed to *how should one live?*). There will be associated *normative* questions such as *What are the priorities for Public Health? How should policy be derived? Who should be involved? How should policy be implemented?* There is a continuum, into more *applied* situations in relation to specific public health policy areas, which EuroPHEN also explored. However, the focus of EuroPHEN was to address *normative* issues.

The rival *normative* theories explored within EuroPHEN address how people *ought* to act, morally speaking. They are not claims about how people *do* act. EuroPHEN has explored how public policy makers *act* by describing the legislation and policies that and how citizens respond to these specific policies. However, it is important to be clear about the distinction between *what ought to be* and *what is*. A claim about how people/professionals *ought to act* should not be mistaken for a description of how people/professionals *actually act*. The importance of this distinction is that it is not possible to disprove an assertion as to what *ought* to be done in a particular circumstance just by producing evidence demonstrating that people/professionals *do not act* in this way. It is also important to distinguish substantive moral claims of *normative* ethics with mere descriptions of the moral beliefs or ethical codes

of some group or organisation. These codes may have legal or quasi legal standing, for example in regulating professional behaviour. However, there is a distinction between how a particular body *thinks* its members should act, as opposed to how they *really* should act. It is also necessary to distinguish the moral from the legal. Just because the law permits or even requires that we act in a certain way, does not mean that such an act or omission is morally valid.

Aim

To derive a framework for producing common approaches to public health policy across the European Union by examining concepts of European and universal ethical standards by conducting work in three areas, namely public health policy and practice; ethical analysis; and empirical research on public attitudes.

Methodology

Three main strains of analysis were carried out within EuroPHEN.

Ethical analysis was performed of tensions between the private and public interest in the context of various ethical theories, principles and traditions including Liberalism, Social Justice, Kantism, Utilitarianism, and Communitarianism. Little work has been done on integrating ethical analysis with empirical research, especially on trade-offs between private and public interests. The disciplines of philosophy and public policy have been weakly connected. Much of the thinking on public health ethics has hitherto been conducted in the United States of America, and an ethical framework for public health within Europe would need to reflect the greater respect for values such as solidarity and integrity which are more highly valued in Europe.

The project systematically compared the organisation of public health structures and public policy responses to selected public health problems in Member States. Our analysis provided insight into how public policy in different countries weighs competing claims of private and public interest, and also grounded the qualitative explorations of the public attitudes to these policies. A number of policies were analysed in greater detail to provide background for the qualitative analysis.

A qualitative analysis was conducted to explore public attitudes and values to public versus private interests for a number of topics including attitudes to community; funding of public services; rights and responsibilities of citizens; rules and regulations; compulsory car seat belts; policies to reduce tobacco consumption; Not-In-My-Back-Yard arguments; banning of smacking of children; legalising cannabis and parental choice with regards to immunisation. 96 focus groups were carried out across 16 European Union Member States (two locations in each country). Focus groups are particularly effective in highlighting both arguments used and the social and cultural context for individual beliefs as well as raising questions and perspectives that may not naturally occur during other qualitative methodologies. In this regard it was felt that while focus groups do not measure strength of opinions held, they would be particularly useful for establishing shared frames of reference and meaning. The groups were segregated according to gender; age (20-30 or 45-60 years); marital status; parental status; standard or further education; smoking status. The focus groups were tape-recorded, transcribed, and translated into English and the transcripts were then analysed and coded

manually. Particular attention was paid to the reason(s) used to by participants to justify their decisions.

Some elements of the work packages of EuroPHEN could have been conducted at a national level, but there are a number of reasons why the project should have been conducted at a European level. For example, the challenge of developing a framework for public health ethics is common to all Member States, and economy of scale and effort will allow them all to benefit from the involvement of ethics and public health experts from across Europe. Research conducted at a European level is more likely to provide information to Member States on the views of all their ethnic communities of European origin.

Implication of Codes of Clinical Ethics for Public Health

Formal and informal professional medical codes of ethics exist in most countries. These ethical standards have tended to concentrate on the morality of interactions between individuals, such as doctor and patient and give limited or no attention to the macro level ethical issues nor the tension between private and public interest.

Many European Codes of conduct require that clinicians make the care of their patient their first concern. Such a requirement has limited meaning in a clinical context where doctors have many patients, and not all can be their *first concern*. At a population level such an edict has even less meaning, although there could be an obligation on a public health professional to make the care of the population for which they are responsible their first concern.

It is important to note that *community* is not a homogenous whole and to recognise that there are different cultures and disenfranchised members within the community. A community is made up of overlapping groups that can have special interests. The health of the population is the aggregation of the health of individuals even though there may be something more that is observed when people come together. Communities are in flux and always changing.

One of the most obvious ways that a clinician must demonstrate respect is in the context of privacy and consent. For clinicians this concerns the privacy of the individual patient and in general doctors must not disclose information to any person without the consent of the patient, unless ordered to do so by a Court or Tribunal. In the case of public health the issue becomes more problematic and disclosure of information maybe necessary to protect the interests of the patient, the welfare of society or of another individual or patient.

Public health institutions should respect the confidentiality of information that can bring harm to an individual or community if made public. All data and information should be respected as confidential, but as at an individual patient level, there may be circumstances when public interest requires that confidentiality should be broken. In such circumstances care must be taken to restrict the breach of confidence to ensure that there really is a genuine public interest requirement and that only the minimum amount of information is disclosed to appropriate third parties, who are also aware of their obligations.

In general consent must be given by the individual before giving any treatment or care, and competency is an important element of informed consent. The requirement to obtain consent before a health professional gives any treatment or care has become a norm within the clinical institution, however with regard to public health it is impossible to inform every member of a community of a public health decision, let alone obtain each person's consent in a meaningful

way. Differences would also be expected with regard to the type of consent mechanisms which different communities will expect. The need to consult and obtain consent is of less importance if public health policies are developed with and owned by the community.

Within a public health setting communicating with populations is much more difficult than listening and talking to a single patient. As such a number of factors must be recognised. Population communication strategies need to be comprehensive to meet the very different needs of all members of the population. Public consultations need to be sophisticated to ensure that the views of as many people as possible in the population are listened to, not just those more skilled in lobbying or in more powerful positions. The means of obtaining this input should be grounded in the needs of the public, embedded within the community itself. Sometimes the process needs to be proactive, sometimes reactive however the methodology regarding the consultancy process must be clear and tailored to the needs of the issue. Particular attention should be paid to identifying disenfranchised members of society. It should be made clear that the process of informing the public about their rights and responsibilities as a citizen is a process that is lifelong, starting with school education.

Clinical professional codes tend to stress the need to respect diversity and not discriminate regarding patients or colleagues on the basis of a range of items (personal beliefs, religion, nationality, race, political affiliation, gender, ethnicity, age, socio-economic grouping or patient disability). At the level of public health policy, certain of these items which are connected to health may be the basis for positive discrimination (age, socio-economic group, patient disability).

Public health ethical codes could contain a requirement to treat people with respect and consideration for dignity, privacy etc at a population level. Respect for dignity and integrity should not be seen as implying that a public health professional must do everything that an individual or even what the majority of a population may want. Rather their interests should be considered along with the interests of other individuals and groups in the population.

The general medical codes make reference to the importance of maintaining and enhancing confidence between physicians and patient, emphasising the duty to maintain a good standard of practice and care. A critical feature of this that the public health professional should be self-reflective as to their own personal beliefs to insure that as far as practicable these should not prejudice decision making. Public health policy should be implemented in a transparent manner that facilitates accountability, including the provision of all information and evidence used to inform the decision making process.

In regard to public health there is a possibility that *conflicts of interests* will be seen to undermining public trust. There should be trust in a public health professional to protect and promote the well-being of the population as a whole. However, this trust has been eroded by various public health scares and scandals, e.g. Bovine Spongiform Encephalopathy (BSE)/ new variant Creutzfeldt-Jakob Disease (CJD), and the combined measles, mumps and rubella (MMR) vaccination.

Public health professionals are continually managing risk, and hence it is appropriate to expect them to identify and minimise risks for a population, just as clinicians are required to minimise risk to patients and clients. However it is impossible to reduce all risk, and the risk for some may increase, in the same way that the interests of a few individuals may be impaired by policy that is in the general societal interest.

The various European clinical codes emphasise the needs of the individual patients over that of the cost of treatment. For a public health professional, prioritisation and resource allocation decisions are a daily reality. Within public health practice it is impossible to avoid making choices between people. At a population level discrimination is required when making prioritisation decisions based on capacity to benefit, cost-effectiveness etc. Sometimes public health professionals become involved in making decisions, when they must discriminate between the interests of individuals, e.g. in communicable disease control. However, the important ethical issue is that this discrimination is fair and equitable. Similarly situated individuals should have equal access to health care services. Where one individual or group has greater capacity to benefit or more people may benefit because an intervention is more cost-effective compared to another, then it is just, indeed arguably ethically required, to make such choices.

Philosophical Theories

Liberalism

The question *what implications does liberalism have to public health policies?* entails different answers depending on the interpretation given to liberalism. For the so-called mainstream welfare liberals the importance of individual autonomy is inviolable but they, unlike the libertarians, claim that human wellbeing requires a certain amount of positive rights and corresponding duties. In primarily self-regarding matters they speak for individual autonomy and for *state neutrality between different conceptions of good*. They value individuality, individual rights, freedom and equality, and their belief in rationality allow them to believe in social improvement.

The most important question concerning the proper limits of individual liberty is whether public health policies and public health care respect people's own wishes and interests, and, at the same time, protect them from each other's conflicting choices, even if it sometimes means that people's preferences have to be laundered in order to achieve tolerance and reciprocal forbearance. If I am ready to participate in medical costs of clogged arteries, caused by indulgence in rich, unhealthy eating habits, an anti-smoking butter-and-eggs eater should be equally ready to participate in costs caused by smoking.

In a liberal society public health authorities should promote autonomy-respecting health programs which ideally aim at rendering people *aware of the conditions of their own health*. What they are not allowed to do is to find ways to manipulate, threaten or coerce people into *choosing* healthier life-styles. Individuals should be entitled to make their own decisions, when these decisions concern *only or primarily themselves*. This means that people can quite legitimately make choices which are bad for their own health. The greater knowledge and impartiality of the authorities guarantee their expertise in the epistemic sense, but when it comes to matters which fall within the scope of people's self-determination and autonomy, they are morally on their own.

Kantian perspectives

Public health programs are driven by the impetus to do good in society and therefore enact moral prescriptions on how to live lives individually and collectively: Many individuals are forced to give up risky behaviour such as smoking, eating fat, living a motionless life or

performing stressful work. Should citizens contribute to the health, prosperity and wealth of the community? How may collective, organized public health measures be productive in this respect? The common approach in public health and public health policy is to discuss *what kind of goals* have to be set and to *what extent* individuals may be *forced*, that is, to what extent public health programs may be voluntary or mandatory. In this respect, public health policy makers and practitioners traditionally act upon their own interpretations of what is in the public interest, although these interpretations diverge throughout the European Union depending on the political and public health traditions in the various member states.

The Kantian, liberalist view, however, puts another question: what *should be* the *social process* through which to set the goals of Public Health and what *should be* the *responsibility of public health professionals*, who claim to do good on behalf of society? On the Kantian, liberalist view autonomy and freedom are not characteristics of isolated individuals living their own separate lives, but are inherent features of social practices leading up to a vital and creative communal life. Public health, collective and coercive measures – do not smoke, do not eat fat, exercise, refrain from stress, etc. – may in fact weaken responsibilities of individuals and communities. If the mishaps associated with driving, smoking, eating fat, exercising too little, living too ambitious lives and other kinds of behaviours considered to be unresponsive to society's needs and goals, carry with them severe social and legal repercussions, citizens may decide to give up all sorts of social behaviour which are vital and creative to individuals and communities. By cutting down responsibilities, individuals and communities may draw the boundaries of their selves and their identities more narrowly than they otherwise would have done. Instead of making explicit public announcements of mandatory measures, the public health community better takes an *interactive* approach with the public and better considers autonomy and freedom as allies to promote the capacity, creativity and vitality of citizens living their lives as members of social networks and society.

Utilitarianism

It is often stated that utilitarianism is the dominant theory behind public health. While there is some truth to this, it presents a gross over-simplification. This is because there is no one definition of utilitarianism nor of public health. The normative content and depth of utilitarianism is to a large degree determined by the definition given to utility, and further prescriptive variations are brought in by the different side-constraints laid upon utility calculations.

Public health is concerned with the health of the whole population and attempts to reduce morbidity or mortality within the whole population. In this way it could be seen to echo the basic utilitarian ideals of impartiality, as the focus is raising the overall health of the public, rather than that of any one individual or group. Utilitarianism tends to make comparisons between various courses of actions and deem one better than the other based on which of alternatives leads to the best end results with the lowest cost e.g. preventive is better (cheaper) than cure. Many public health interventions e.g. vaccinations and water fluoridation, are justified by variations of the utilitarian credo that we should aim at *the greatest happiness of the greatest number*. The occasional adverse effects are seen to be acceptable because of the benefits to the rest. Similarly the more drastic measures sometimes taken in the name of public health, like quarantine, are justified by the benefits to the many. Utilitarianism is often criticised for allowing the sacrifice of individuals in the name of benefit to the greatest number and here Public Health faces similar kinds of charges. Jeremy Bentham might have allowed the sacrifice of individuals because of public health considerations, whereas John Stuart Mill, found it necessary to restrict utilitarian considerations with those of individual

liberty. While Mill might have allowed quarantine because of harm to others' considerations, and would have allowed warnings on products known to be dangerous to one's health, he might have had a thing or two to say about banning self-harming goods and about other clearly coercive measures.

Side-constraints are also called for by today's Public Health authorities. Most feel that there are limits to the sacrifices that can be asked for in order to reach the greatest health benefits. If public health were utilitarian, it would most likely be described as objective and ideal, rather than subjective or preference related. That is, health as the goal is for the most given objective criteria and it is seen as an ideal. Whether Public Health would be described as positive or negative utilitarianism will depend on whether the emphasis in the definition is given to reducing ill-health or to increasing the overall health. Public health tends to assess each intervention on its own merits which would fit better with the ideals of act utilitarianism than rule utilitarianism. To the degree that public health is interested in the cost-effectiveness of its methods, it comes closer to economic utilitarianism (this is sometimes called health economics) than to the moral and political forms of utilitarianism. Preference utilitarians have problems with the objectivity of the definition of *the good* in public health, and even more Utilitarians would find the idea of health as the main good to be promoted too narrow in scope. Those Utilitarians with Millian ideas on the importance of individual liberty would find the paternalistic undertones of public health difficult to accept; and while most Utilitarians would praise the impartiality of public health, many find its emphasis on the collective unsatisfactory.

Solidarity

Individuals may be motivated to act in the interests of others out of a sense of solidarity. This is an awareness of unity and a willingness to bear the consequences of it. Through our societal role we are a member of various groups. For example, family, religious group, ethnic sub-population, each group is defined in terms of a common history, common convictions and ideals. The group is linked by a desire to further *common interests* or by *interests in common* which motivate collective action. Within group solidarity, the main focus is on the best interests of the group. The individual is part of the group and benefits if the group flourishes, but it is the collective interest that is the main concern. Within moral solidarity, the main focus is a third party individual and what doing things for them because it is the right thing to do. While there may be some expectation that others would act in the same way if the positions were reversed, in the pure sense of moral solidarity, the action is purely altruistic, and there is no expectation of personal reward of acting morally in doing the *right thing*. Within constitutive solidarity, the main focus is the individual themselves. They are working with other people, and so indirectly assisting others to advance their goals but the focus is benefit to self.

Communitarianism

Liberal theories give priority to the rights of the individual above those of society. The individualists tend to distinguish between who one is and the values one has. Rawls attempted to make this distinction in his description of the *original position* and the *veil of ignorance* in which participants are supposed to be ignorant of any information about their beliefs, norms, class, status, etc. Sandel argued that the liberal vision of the individual as the autonomous chooser of his or her own purposes presupposes that the chooser is sufficiently sovereign over, and therefore distanced from them.

Communitarians believe that this conception of the self is illogical. A self that is as open-ended as the liberal conception requires would not be so much free as *identity-less*. Only a *thickly constituted self* shaped in its very being by traditions, attachments, and more or less irrevocable moral commitments can actually make choices that count. Individualists fail to recognise that membership of a community is not necessarily voluntary, and that the social attachments which determine the self are not necessarily chosen ones. MacIntyre argued that one understands a person's life only by looking at his/her actions within a story, a *narrative*. Each person's narrative converges with the narratives of other people, who in turn become part of each other's narrative. The community (family, tribe, neighbourhood) sets up the form and structure for these narratives. Taylor, went further and instead of seeing community as being important in interpreting the individual sphere, he believed that community was a precondition for moral autonomy. Taylor argued that even the extreme libertarian acquires the desire for individual autonomy by virtue of participating in a civilisation that has learned, over the course of many centuries, to put a premium upon such aspirations. Taken out of a social-historical context, the very desire for control over one's autonomy would be void of meaning. Therefore, precisely those aspirations that define the autonomous individual are the expression of a debt to one's society, and hence represent social obligations, that are overlooked in libertarian theories.

In order to be sustainable, moral principles should be congruous with the values and practices of the society in which they are to be applied. One of the consequences of this is that it may not be possible to conceive morality in universal terms. Universal and absolute justice, for example, may be another illusion of individualism. Since the values that people hold derive from their communities, it is feasible that concepts such as justice may not be universal or absolute, if each community has a different understanding of what such moral values entail. Walzer argued that it is not possible to talk about justice without considering the sorts of goods that a particular society distributes among its members. Of course, these goods can also be socially constituted by shared experiences, communal meanings, and traditions of self-understanding that evolve through history. Therefore liberal justice cannot presume to maintain neutrality toward ends and goods.

When an individual attempts to define their personal moral code they ask *who am I? how am I situated?* and *what is to my benefit?* as well as establishing *what is good for the community?*, because, as Sandel pointed out, we are "*partly defined by the communities we inhabit*" and are therefore "*implicated in the purposes and ends characteristic of those communities.*" The exclusive pursuit of private interest erodes the network of social environments on which we all depend. The ability of an individual to exercise their autonomy depends upon the active maintenance of the institutions of civil society where citizens learn respect for others as well as self-respect. Similarly community flourishing is dependent upon the contribution of its members to shared projects. The relationship of private and public interest is manifested by a mesh of complimentary and reciprocal rights and duties. There is a recognition that there are common challenges faced by members of a community which can be addressed by common thought if not common action, with a spirit of solidarity to provide a voice and support for less well situated community members.

Personalism

Personalism is a wide-ranging cultural movement which can be divided into several trends from a philosophical viewpoint, but they have in common that their position is integrated and

re-elaborated within a ‘foundational’ perspective and a particular philosophical anthropology: it considers the human person integrally and adequately understood. Some of the elements within personalism are particularly relevant in terms of public health ethics: (a) Respect for life: public health actions are aimed at protecting and promoting human life and health; (b) Sociality and solidarity: social solidarity means and contains a commitment to bridge the gap between the different segments in society and to integrate them into a community; (c) Responsibility: the responsibility to prevent and protect from avoidable diseases; the duty not to create irresponsible burdens for the society; the responsibility for people in need. This responsibility is also related to co-responsibility, where there is an encounter between the individual and collective responsibility.

Analysis of Public Health Structures and Policies

There is considerable variation between EuroPHEN countries in terms of the funding and organisation of health services and public health, for a combination of historical and political reasons. In some countries, public health is a branch of medicine, in others it does not exist as a medical specialty, in others it is a multi-disciplinary specialty, and in yet others it is not recognised as a profession in its own right. These factors also impact on the breadth of public health practice, ranging from biomedical interventions to policies to address inequalities. For details see full report.

Whilst most EU countries have comprehensive health policies which seek to prevent disease as well as develop health services, it does not necessarily mean that they have public health *systems*, such as an organised or connected group of agencies with a primary public health focus. In addition, methods of improving the health of the population depend upon a number of interrelated factors. These include: time; place; government style and political direction; degree of authority vested in, and exerted by, the state. Public health practice also varies according to the disciplinary base which may be narrow, predominantly focused on a medical model, or may be broader including a wider range of disciplines including political sciences. Public health practice also varies in response to new and urgent health priorities and changing governments and government bodies.

Individual countries within the EU are also expected to vary regard their underlying moral values and importance given to private versus public interests. This project has attempted to explore some of these concerns, however it should be noted that this is difficult due to methodological issues. We found that some countries tend to adopt relatively consistent patterns of the degree of liberalism versus paternalism whatever the public health issue studied (for example, Scandinavian countries tend to be more paternalistic, Western and southern European are more liberal). In addition, there is a degree of consistency between which public health policies are more liberal versus paternalistic depending on the issue, irrespective of the individual country (tobacco control and communicable disease control tend to have more paternalistic policies).

Returning to the issue of principle of subsidiarity one can question to what extent these differences between public health structures is a concern. Common to all aspects of European Public Health is the shared interest of European Union to provide its population with opportunities for better health and ensuring a high level of human health protection. The precise mechanisms, structures and policies which each country uses to pursue these goals are likely to have greater efficacy as allowances can be made for differences in epidemiology, historical and moral weighting.

In the areas where the EU has not sought to harmonise policies between Member States through Directives, individual countries may be expected to vary to a greater extent and reflect their underlying moral values. Indeed we found through the analysis on the philosophical basis of public health policies revealed that there is a wide variation within and between the countries examined in terms of the degree of paternalism versus liberalism in their approach to the various public policies examined.

Most countries are paternalistic with regards smoking and communicable disease control, and the general trend is to increase the degree of paternalism with regards these two areas of policy. With regards smoking, the EU has led the way for increasing state control over smoking in public places, advertisement, sponsorship, and health warnings on packaging, and all countries have followed this guidance although Germany is slower than others, due to influential tobacco lobbyists and an emphasis on personal freedom in lifestyles.

With regards communicable disease control, the increased profile of this area of public health following real or threatened international outbreaks and incidents (the rise of tuberculosis, SARS, avian and pandemic flu, bioterrorism) has led to the development of new legislation in some countries which increase the state's power to contain and control, within limits.

The Scandinavian countries, together with Poland, also tend to be more paternalistic within drugs policy compared to other western European countries. However many of the previously more liberal countries are now moving towards a more paternalistic goal of abstinence rather than harm reduction, perhaps as a consequence of a previously more liberal approach which is perceived to have failed or due to European politics.

Immunisation policy is perhaps surprisingly more liberal in Scandinavia but this may be due to a historical high level of trust in the authorities thereby requiring less legislation to ensure adequate levels of vaccination coverage.

There are explicit laws to regulate genetic testing in employment and prohibit discrimination in many Member States. Although in many countries there are exemptions from the protection of individual rights if testing would protect self and/ or others. Most countries are non-specific with regards to discrimination on the grounds of genetic tests. Because of the complexity of this issue and the continuous advances of this branch of science, these issues are under review in many countries and most seek to protect the individual worker. The overall direction is to be more paternalistic in terms of laws and punishments for non-compliance in order to protect the individual's rights, with exemptions in certain situations, in keeping with EU regulations.

There is increasing protection of children and vulnerable adults in clinical research across most countries in order to protect the individual rather than undertake research for the public good in line with EU Directives and the Declaration of Helsinki. There is variation in the degree to which these are implemented and worded and questions remain as to whether they provide the level of protection envisaged in practice. Austria, Spain, the UK and Ireland have only partial or no formal restrictions on payments to adults with capacity, a more liberal approach than the other countries which restrict this. Austria, Germany, Italy and Sweden require the appointment of a proxy for the purposes of consent in incapacitated adults to be made through the courts, in other countries it is more liberal. Germany has the greatest restriction on research in children, and also has the greatest protection for pregnant women in

research. This more paternalistic approach to protect the individual may be related to historical factors relating to the Nazi era.

Understanding how historical events and underlying moral values have shaped contemporary public policy is important to the development of international public health policy. Although all EU countries are subject to various Directives, these are translated into practice in different ways and to different degrees depending on the *fit* with existing policies and practices. The Scandinavian countries have a stronger history of paternalism with regards public policy and this is evident in the sections above. Childhood immunisation is a notable exception, although this may be due to a strong historical trust in authority as noted above which has not necessitated state intervention. Another notable exception is Germany which has public policy which differs from the European norm in two main areas: that of tobacco control where it is more liberal, and that of the protection of research subjects where it is more paternalistic. It has been speculated that this may be related to activities of the Nazi era, with contemporary governments keen to not repeat events of the past. Poland stands out in a number of areas of public policy as being more paternalistic than some other countries, in particular immunisation, communicable disease control, and drugs policy, these may be related to its communist past. Ireland generally is congruous with other member states except in the field of water fluoridation where it is the most paternalistic of all countries as the only country to mandatory fluoridate water supplies. Southern and Western European countries are generally more liberal, for example in terms of drugs policy, although France and Belgium are unusual in not banning corporal punishment in educational settings to protect children.

In summary, some countries tend to adopt relatively consistent patterns of the degree of liberalism versus paternalism whatever the public health issue studied (for example, Scandinavian countries tend to be more paternalistic, Western and southern European are more liberal). In addition, there is a degree of consistency between which public health policies are more liberal versus paternalistic depending on the issue, irrespective of the individual country (tobacco control and communicable disease control tend to have more paternalistic policies).

Empirical research on public attitudes

Attitudes to a smacking ban

No consensus was observed regarding the merits or demerits of smacking children among the focus group participants. There was however a general consensus that a ban on smacking was neither useful nor desirable by the majority of participants in most countries except Sweden and Finland where legislation has been in place for some time. In summary, the right of a parent to choose whether to smack or not appears strongly defended in most countries.

Attitudes to regulation regarding wearing car seat belts

Most focus group participants were convinced of the benefits of seat belt use and hence restrictions in personal freedom may be perceived as less severe if one wears a seat belt habitually. Habitual behaviour has been recognised as one of the most influential factors in improving overall compliance rates and its importance is reflected in the focus group data, being used to reinforce reasoning for both regular and irregular use of seatbelts. The focus groups highlighted the inconsistencies in seat belt use dependent on the journey taken and the perceived risk of having an accident, despite a widespread agreement on the safety benefits of

seat belts. The problems identified in the focus group data regarding law enforcement are a cause for concern. In order to effectively promote seat belt use it is necessary for the police to adhere to as well as enforce the law, especially with such strong majority support for seat belts.

Attitudes to legalising cannabis

Therapeutic use of cannabis was regarded as acceptable by most respondents, in contrast, weak support was expressed for legalising possession and use by the general public. There was an association between perceived harm of cannabis and respondents' support of legalisation. This was consistent with the views of harm for cigarettes and alcohol. Slight variations were observed within age groups, with older groups expressing stronger opposition to legalisation. Creation of new users was clearly the main concern, with potential benefits including increased revenue through taxation and the regulation of cannabis products to minimise health impacts. There was little support amongst the general public for increased prosecution of personal possession and use. It may be that respondents supported efforts to separate and regulate soft and hard drug markets to combat cannabis acting as a *gateway* to hard drugs or excessive use of soft drugs. This research indicates that to counter cannabis acting as a *gateway* it may be more effective to exploit the existing view held by the general public that cannabis is a soft drug in contrast to other highly addictive and damaging hard drugs.

Attitudes to water fluoridation

Most participants were against water fluoridation, although groups in Greece, Ireland, Poland, and Sweden were more in favour. Many felt dental health was an issue to be dealt with at the level of the individual, rather than a solution to be imposed *en masse*. While people accepted that some children were not encouraged to brush their teeth, they proposed other solutions to addressing these needs rather than having a solution of unproved safety imposed on them by public health authorities that they did not fully trust. They did not see why they should accept potential side-effects in order that a minority may benefit. In particular water was something that should be kept as pure as possible, even though it was recognised that it already contains many additives. In summary while the vast majority of people opposed water fluoridation, this may be indicative of shifts away from public support of population interventions towards private interventions, as well as reduced trust in public agencies. Thus if research were to demonstrate more clear benefits of water fluoridation over and above that which can be achieved by use of fluoride toothpaste, then the public may become more supportive. However, lobby groups are likely to remain influential.

Attitudes towards compulsory immunisation

Support for compulsory immunisation was strongest in countries where certain immunisations are already compulsory (Greece, Italy and Poland). In most other countries discussions focused on the concept of risk (both to the individual and to other people), perceptions of infectious disease as a *foreign threat*, issues of trust in the advice of health professionals and fears over vaccine safety. The question of parental choice versus State compulsion was very much a secondary concern. The data suggests that the public's continuing concern over the safety of (particular) vaccinations must be addressed if levels of immunisation coverage are to be increased and maintained. Focus group participants held most trust in the advice of their family doctors and these health professionals need to be supported in their commitment to immunisation if they are to encourage concerned parents to have their children immunised.

Attitudes towards a smoking ban in public places

There was strong support for the state encouraging people to stop smoking; however paternalistic approaches such as a total ban and raising taxes were not widely supported. There was widespread support, including among smokers, for smoking restrictions in public places, however this was because smoking was seen as being anti-social rather than because of the health effects of passive smoking. Smokers were concerned that they were increasingly stigmatised. Defining what counted as a public space was seen as problematic and required a pragmatic approach. The data indicates that smoking regulation plays an important role in defining a non-smoking environment, as well as setting social norms and expectations. Regulation also plays an important part in allowing people to request others not to smoke.

Attitudes to *Not-In-My-Back-Yard* issues

The questions about how focus group participants felt about plans to build a home for people with mental illness in their neighbourhood formed part of a larger discussion about *Not-In-My-Back-Yard* (NIMBY) issues, and trust in information provided by government and public agencies. In addition to asking about how the focus groups felt about building a home for people with mental illness in their neighbourhood, they were also asked similar questions about plans to build a mobile phone mast and a chemical plant making everyday items, like plastic or pharmaceuticals. Familiarity with mental illness inversely predicted the perception of dangerousness of people with schizophrenia and to a lesser extent also inversely associated with fear and social distance. Familiarity was also inversely associated with perceived dangerousness of and desire for social distance from people with major depression. On the whole, participants within the focus groups who had some degree of familiarity with mental illness tended to be more positive about locating a home for people with mental illness in their neighbourhood.

Attitudes towards obeying rules and social norms

The focus group participants were asked whether they would obey a sign saying they should not walk on the grass. The major justification for the respondents' behaviour was based on the likely consequence of disregarding the sign. The sign acted to prime participants to the state/health of the grass, but also to the grass as the outcome of the park keepers' work and hence the impact of their action on others' *work* and *efforts*. In this regard they were also highly conscious that it was not the consequence of their single action but the collective impact of many people walking on the same route which was likely to cause harm. While a few respondents did mention the possibility of being fined, the possibility of being told off (or to move) and being seen to be breaking a social norm was more important. In addition respondents were aware that their own actions would be used by others to justify breaking the rule and lead to greater harm to the grass and they were therefore willing to obey the sign to *set an example*.

Attitudes to parental rights

State involvement in public health policies related to the upbringing of children was not always accepted by focus group participants. The majority stated that parents were probably the best judge of their children's interests, although they agreed that in extreme cases the State should intervene. There were discussions on the influence of the State and concerns were raised about a *slippery slope* of government involvement. Participants acknowledged parents' obligation to

act as role models. A number of participants employed the *greater good* argument and stated that they would accept a public health measure that would be beneficial to vulnerable members of society, even if it infringed on their rights as parents. Questions were raised regarding trust and the enforceability of policies. In summary focus group participants felt that a parent's right to bring up their child as they wished should be respected. Although in principle they believed that the State was generally acting in the public interest and accepted State guidance, some participants rejected State intervention on the grounds that these interfered with individual choice.

Attitudes to incentives and enforcement

Focus group participants generally expressed a preference for incentives rather than enforcement in relation to immunisation, smoking and fluoridation. Many participants felt that if they were given good clear information then most people would voluntarily choose to accept a public health measure perceived as beneficial to (sections of) the population. Social pressure and pressure from health professionals were also cited as incentives to act or not act in certain ways, including taking the decision to immunise and to not smoke in public places. Participants also expressed concern over the difficulties in enforcing measures such as a ban on smacking children in the home. The data suggests that public health policies are more likely to succeed and have the greatest support where incentives, rather than enforcements, guide behaviour and leave the public with some elements of choice and control.

Attitudes to trust

Trust in government is low following recent food and health scares throughout Europe. With regard to the various public health policies explored in the focus groups, participants did not totally trust the information they were given by government sources, but in similarity with other studies the participants were more trusting if the information came from sources seen as independent such as scientists, health professionals or family doctors. Most felt that they should have access to all the information so that they could make their own decisions and that this information should be provided by experts who were independent from economic interests. However they were also aware that such openness carried the potential that information may be misunderstood, cause unnecessary worry/panic and harm national security interests. Overall the participants accepted some censorship of information which they characterised as different from the State actively publicising misleading information.

Attitudes to community

Most of the focus group participants took a broad view of community, able to identify different communities that they belonged to, and with what degree of attachment. The most important community was the family and immediate social networks, which were usually geographically defined although not entirely. In the younger age groups, more reference was made to global and virtual communities, reflecting their assurance with technology and possibly a politics that encompasses specific issues rather than a geographically rooted politics (i.e. municipal). Some of the in-country views were coloured by recent historical events – bombings and terrorist acts, the unification of Germany, post-communist society in Poland. There were issues around ethnic groupings raised in many of the groups – mainly *outsider* groups which were often singled out as being different, and threatening in some way – either by affecting national identity, or just by their *difference* which was a source of anxiety. This was more often apparent in the older demographic, but not entirely – in the UK

younger fathers were vocal in expressing views that seem to demonise certain ethnic groups. Society and community are concepts that are used to define a set of values – and people identify such values more easily on a smaller scale although many accept that they *belong* to more than their local communities and families. Community and social networks were acknowledged to be important to the health of society and the sense of well-being that people have, but there was also an awareness of the possibility of unhealthy communities – corrupt, bullying and/ or threatening ones. The past was not always considered to have been better than the present – with a few exceptions. Most people accepted that there were societal benefits from closer neighbourhood networks, but they were equally quick to point out the disadvantages – the *nosey neighbour* syndrome. However some of the groups were very concerned about youth – young people growing up with material benefits but no parental guidance – rich and poor alike. Fear of youth was expressed in some of the groups, pity in others. The fast pace of life was commented on by many of the groups, but there did not appear to be any desire to give up the material benefit that work often brings to return to the past. There were exceptions – Poland being notable, though in this case, very little material benefit had flowed from the collapse of communism to the respondents who expressed the most dissatisfaction with their society.

Attitudes to Solidarity

Focus respondents were asked whether they preferred to live in a country where the government provides a high level of public services, but taxes are high to pay for them (Country 1) or one where taxes are low but people are expected to pay for insurance in case they become unemployed or ill and to make provision and social care when they are older (Country 2). The main advantages of Country 1 were seen as being that everyone is taken care of and has the same opportunities within a more mature and caring society. The disadvantages of country 1 were seen as a lack of choice, inefficiency, abuse by *scroungers* and loss of motivation and vibrancy in the wider society. The advantages of an individual model of society within Country 2 were principally promotion of enterprise, entrepreneurship, activity, creativity, enthusiasm, hard work, greater efficiency and competition leading to greater choice and ultimately improved standards of public provision. The minority of participants who leaned towards this system were all confident in their ability to prosper and play the system to maximum advantage to them. The disadvantages attached to Country 2 were significantly harsher than those attached to Country 1 – and for people *repelled* by this system these disadvantages were completely untenable. The disadvantages of Country 2 were the perpetuation of inequality, social unease, crime, anxiety and worry. Generally the majority felt that the foolish should be taken care of as well – based largely on the fear that *it could happen to me*. Overall the majority of the respondents involved in the study would prefer to live in country 1. Few, however, reason in *black and white* and for all but a few countries a mid-point appears most desirable and realistic. Even groups that expressed a preference for country 1 demonstrated a certain malaise or dissatisfaction with a *nanny state*.

Attitudes to Rights and Responsibilities

Many found it relatively easy to give examples of their *rights* but much more difficult to think of responsibilities. The most frequently mentioned rights (in order of frequency) were: right to an education; right to healthcare; freedom of speech/thought; freedom of choice; right to vote/democracy; right to basic level of income/pension/ social benefits; justice/civil rights/right to protest; right to work/not work; personal safety/security; housing; freedom to practice religion; respect/dignity; enough food and basic life needs; right to free movement

and travel; equality; right to life/die; freedom of association/membership of trade union or political party. In order of frequency, the duties spontaneously mentioned were: to have public spirit, civil courage, show solidarity and contribute to society; to obey the law; pay tax; respect others; to look after your family especially children (and insure that they are educated) and the elderly; behave responsibly; respect environment; look after your self; to vote; to work; military service.

Most groups recognised that it was human nature to want rights rather than responsibilities and having more rights than responsibilities should be the norm in a liberal society. Some blamed the media for the greater attention paid to rights rather than responsibilities. Young men with families, particularly in the UK, felt that their responsibilities extended to themselves and their families only. Many thought that paying tax off-set the majority of responsibilities. People felt that there was a power imbalance with the State enforcing citizen responsibilities but not their rights and that they were not consulted and what responsibilities they should have as citizens.

However, it was also recognised that people may have responsibilities, but this does not always mean that they fulfil these duties. It was suggested that the perceived breakdown in society was in part because responsibilities were not enforced. Responsibilities were not always seen as being bad. Indeed, some wanted more responsibilities or felt that some citizens abuse their rights. Responsibilities were more oriented towards the personal or individual rather than society, with a loss of what is termed *civic courage*. It was recognised that citizens should have responsibilities in order for society to function and that rights come with responsibilities. It was important to act in the way that you would want others to behave towards you. Living in a community, personal freedoms may have to be constrained if there were consequences for others. Some participants criticised those who wanted to isolate themselves from society and the associated duties as a citizen. Many participants discussed rights and responsibilities in terms of a social contract. If rights were not protected by the State and citizens did not get anything in return for upholding responsibilities, many people did not feel an obligation towards social duties.

Self-Interested Altruism and 'It-Could-Be-Me'

Almost every respondent ended up expressing a clear preference for *Country 1*, and most of these motivated their stand in ways pointing towards a stance that can be broadly described as solidaric. However, one particular minority reasoned in a more complex way. They started out with an initial preference for *Country 2*, motivating this stand with the claim that they would fare well within this type of policy, while recognising that several others would not, and therefore benefit more by it (due to lower taxes and access to a larger range of alternative health service providers). However, having made this initial declaration, they then added that although they indeed believed themselves not to belong to the *losers* in *Country 2*, *it could be me* (ICBM), and on this basis they concluded that, all in all, C1 was after all the more desirable option.

In our modern consumerist society, appeals to individuals to acquiesce to public policy that may not appear to be compatible with their direct or immediate private, interest, may not be effective. Of course, individuals may feel good by acting out of what appears to be altruism, but when designing messages for the public, policy makers need to ensure that citizens implicitly understand what they will be getting out of the policy in terms of their second order preferences. For example, that it will save them having to pay tax in the long run, or they

would be similarly supported if it were to happen to them in the future, or it means that they may live in a society compatible with their goals. Thus policy makers need to be much more sophisticated in their campaign messages and hence need to research public attitudes, concerns and motivations more carefully. While the principle of autonomy is not a good basis for deriving an ethical framework for public health practice, political realities mean that if policy is to bring about improvements to the public health in a consumerist society, it will be necessary to work in partnership with the *self-interested altruist*.

Conclusions

The societal practice of public health is driven by goals that are expressed explicitly by various policy documents and regulations and/or implicitly by the way in which public health is organised, structured and motivated. Even if obvious ambiguities built into notions such as *public* and *health* are disregarded, there is a significant variation between European countries, as well as between different temporal eras of one and the same European country, with regard to what these goals are taken to be. From the point of view of a forthcoming European harmonisation of public health this fact is a serious challenge. Three main types of goals in this respect are proposed: promotion of population health; promotion of health related autonomy and promotion of health-related equality. Thus it is necessary to address the issue of what the goals of public health *should* be, and relate this issue to the more specific query of whether different types of goals may be appropriate for different countries depending on further factors, such as economic growth, actual health levels, etc. Answering this question affirmatively, it is concluded that a European policy of Public Health will have to adopt a complex, pluralistic and dynamic goal structure, capable of accommodating variations in what specific goals should be prioritised in the specific socio-economic settings of individual countries.

Policy implications

The EuroPHEN partners do not wish to make specific recommendations with regards to a code of professional ethics for Public Health. The normative framework that should underpin public health and issues in its implementation are laid out within the entire report.

Of particular importance are the sections of the report relating to the values of public health, and the challenge posed to public health professionals to reconsider their relationship with the public and the goals underpinning policy.

There are differences in approach to policy between Member States, which reflect local circumstances in terms of epidemiology and history, as well as variation in moral weight given to public versus private interest. However, these differences do not represent insurmountable challenges to developing professional codes for Public Health to be used within Member States or European Union institutions, nor for developing policy and European Directives.

The empirical research demonstrates current thinking among citizens towards public health and public policy more generally. The research also provides an indication of more effective ways of developing and implementing policy that attracts greater public support.

In summary, the following points should be considered:

- 1 Public health should strive to create an environment and structures that facilitate individual health, wellbeing and flourishing, and facilitate the interdependency between individuals necessary to achieve individual flourishing.
- 2 Public health should achieve population health in a way that respects the rights of individuals and the interests and interdependencies of communities. For some communities individual-focus bioethics is likely to be unsuitable and policy makers must be sensitive to the different needs and moral values of different communities.
- 3 Public health policies must take heed of the pre-eminence of autonomy in European society. However, the ability of citizens to make autonomous choices, sometimes for what may appear to be irrational behaviours that put them at increased risk of morbidity or mortality, should not be seen as an impediment to making improvements in the health of the public. Indeed, central to the normative framework proposed by EuroPHEN is the need to strengthen the autonomy of the public to promote the capacity, creativity and vitality of citizens living their lives as members of social networks and society.
- 4 Citizens consider themselves as *consumers* of healthcare who see health services as their *right* as tax payers. However rights have reciprocal responsibilities, and the public must be reminded of these. The method of informing the public about their rights and responsibilities as a citizen is a process that is lifelong, starting with school education.
- 5 Public health has a strong role to play in ensuring that people feel part of a society so that they can make a contribution to society. Identifying disenfranchised members of society is difficult because by definition they tend to be invisible and inaudible. They may not want to be identified because they think society is not relevant to them.
- 6 The public are unlikely to support policies which they do not understand or which they see as unconnected to their lives.
- 7 Public health policy should be implemented in a transparent manner that facilitates accountability, including the provision of all information and evidence used to inform the decision making process. Policies which are seen as un-enforceable will not only decrease support but also weaken support for public health policies in general.
- 8 There is a need to actively build trust in public health policy and for public health structures to be seen as independent from lobby groups, political, commercial and monetary influence.
- 9 A balanced approach is required between incentives and restrictions. The public generally prefer incentives to change behaviour etc, rather than more explicit, direct restrictions on what may be considered to be civil liberties. However, public health polices must be cautious regarding the use of inducements as these can create distrust. Inducements directed towards the medical suppliers of public health services can be seen as creating commercial interests which may biased what is best for the individual. Inducements directed at the general public can raise *conspiracy* type worries, especially in those cases where public information is lacking or where there is conflicting information given from alternative sources.

10 Public health institutions should respect the confidentiality of information that can bring harm to an individual or community if made public. In cases where there is high likelihood of significant harm to the individual or others, suitable mechanisms should be in place to retain a level of confidentiality that minimises the breach in privacy.

11 Where there are risks to health, public health institutions should act in a timely manner on the information available, taking into account the reliability of the data and other priorities.

Future Research needs

Further qualitative research

It would be beneficial to conduct further qualitative research focusing on the meaning of community and solidarity. The research could explore to what extent they are important within a 21st concept of citizenship and community. EuroPHEN conducted focus groups in 16 countries, but in further research it may be more effective to reduce the countries, but increase the demographics groups studied, and to have similar group profiles in all countries researched. It would be beneficial to explore these concepts in specific groups e.g. ethnic/religious groups, gay community etc. EuroPHEN included Poland, but with the further expansion of the EU, additional perspectives should be included by conducting the research in other central and eastern European countries and Turkey.

It seems to be a valuable prospect to conduct such research on the basis of developed versions of the initial focus group methodology. Among other things, adapted elements from other methodologies (for example, willingness to pay approaches), may be brought into the focus group set-up to facilitate more close investigations of attitudes to conflicts of interest, community concepts, etc

Quantitative research

The findings of EuroPHEN should be used to develop questionnaire surveys. Health economics techniques could be used to assess strength of support/opposition to Public Health policy e.g. willingness to pay, or compensation required.

Of particular interest is to survey, first, attitudes to particular types of policies/policy areas, and, second, particular types of value sets that may conflict in the public health context – such as, equality, economic and social efficiency, community autonomy, and individual liberty. It is moreover of interest to correlate the results of such surveys to economic features (such as growth) of the nations of the respondents, religious confession etc.

In light of the results of EuroPHEN, one other factor which is of considerable interest to survey quantitatively is citizens trust in various social institutions with regard to issues related to public health and health policy. Comparisons between different countries and connections to other issues, such as the development of ethical guidelines for the public health profession, and the value sets mentioned above.

Research with the Public Health Community

It was originally the intention of the EuroPHEN Partners to develop an ethics normative framework that could be used by public health professionals. The partners decided that further work would be needed to do this involving a consultation process, similar to that used by the Public Health Leadership Society in the USA. Although the EuroPHEN Partners do not feel that a list of principles would not be helpful, as it could address the complexity of public health practice in its various settings. This consultation should also include a discussion of goals and methods of Public Health and examine the impact of private sector, lobby groups.

There are three basic models for how this may be done: 1) a top-down approach, where public health agencies and organisations (e.g. the European Public Health Association [EUPHA] and the professional bodies in Member States) are brought together to create a shared outlook. 2) a bottom-up approach, where the ideas of individual Public Health-professionals are surveyed in various ways (using quantitative and/or qualitative methodologies). 3) a combination of these. Of these, the third option looks like the most promising, but it is also methodologically challenging when it comes to bringing the *top* and the *bottom* together. In the first instance, an international conference could be organised to initiate this process.

Conceptual projects

Perhaps the most important issue arising from the EuroPHEN report is the need to further consider the goals of Public Health. This is an important conceptual task for Public Health Professionals, public, politicians and other stakeholders.

Further philosophical research is required to explore concepts such as solidarity, equality and attitudes to risk. Such research should attempt to describe what specific public health policies would look like if based on a particular normative framework, to examine the differences between liberal, Kantian, communitarian, utilitarian approaches. It would also be beneficial to consider how to communicate/promote *public* values in *private* societies.

With special consideration to European harmonisation in the area of public health, it is of interest to relate these investigations to broader considerations about the forms and ideologies of European secularised societies, since these approach issues about the various points of conflicts between general society, sub-community- and individual interests mentioned above. It also connects to the issue of the importance of trust, and the related and crucial issue of who or what should be given the power/authority to represent the basis of knowledge that needs to underpin any activity within the public health area

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1 Definition of Public Health

In 1952 the WHO defined public health as *“the science and art of preventing disease, prolonging life and promoting mental and physical health and efficiency through the organised community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organisation of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of social machinery to ensure to every individual a standard of living adequate for the maintenance of health, so organising these benefits as to enable every citizen to realise his (sic) birthright of health and longevity”*.¹

This early definition proved controversial for failing to capture the breadth of public health action and the aims of public health which extend beyond improving health *per se*, such as equity on the distribution of health in a population and the creation of societal conditions to allow healthy choices to be made if desired.

As a consequence, other definitions have evolved over time, such as that used in the influential Acheson Report on the public health function in England² as *“the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society”*. This is the definition adopted by the UK Faculty of Public Health, which also states that public health: *“is population based; emphasises collective responsibility for health, its protection and disease prevention; recognises the key role of the state, linked to a concern for the underlying socio-economic and wider determinants of health, as well as disease; and emphasises partnerships with all those who contribute to the health of the population”*.³

The definition above was modified further in another UK report into the public health function⁴, to include a more explicit definition of the breadth of involvement of society, *“the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals”*.

Other definitions include the American Institute of Medicine’s report on the Future of Public Health.⁵ This defines the mission of public health as *“...fulfilling society’s interest in assuring conditions in which people can be healthy. Its aim is to generate organised community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health. The mission of public health is addressed by private organisations and individuals as well as by public agencies”*.

A later publication from the USA Public Health Service outlined the ten core activities of public health as: *“preventing epidemics; protecting the environment, workplaces, food and water; promoting healthy behaviour; monitoring the health status of the population; mobilising community action; responding to disasters; assuring the quality, accessibility, and accountability of medical care; reaching out to link high risk and hard to reach people to needed services; researching to develop new insights and innovative solutions; and leading the development of sound health policy and planning”*.⁶

A former Harvard Professor of Public Health stated that Public Health *“is concerned with preserving and enhancing the health of populations...What is the distinction between medicine and public health?...In general, as a personal physician aims to maintain the health*

*and to diagnose and treat diseases in an individual, the goal of the public health professional is to understand and meet the health needs of communities, groups, and nations. Where medicine follows a personal service ethic, conditioned by an awareness of social responsibilities, public health is governed by an ethic of public service, tempered by concern for the individual”.*⁷

Public health practice has also been characterised by⁸: its emphasis on collective responsibility for health and the prime role of the state in protecting and promoting the public's health; a focus on whole populations; an emphasis on prevention, especially the population strategy for primary prevention; a concern for the underlying socio-economic determinants of health and disease, as well as the more proximal risk factors; a partnership with the populations served.

It has been noted that despite the range of definitions of public health, they have the following features in common: the general public interest; a focus on the broader determinants of health; and a desire to improve the health of the entire population.⁹ Earlier definitions also referred to the administration of health care services.

In recognition of the need for a clear, unifying vision of public health, a recent definition has been proposed, “*collective action for sustained population-wide health improvement*”⁹ The authors of this definition have identified five key themes of modern public health practice, these are: leadership of the entire health system; collaborative actions across all sectors; a multi-disciplinary approach to all determinants of health; political engagement in the development of public-health policy; and developing partnerships with the populations served. The authors state that whilst each theme is required in modern public health practice, these themes are seldom reflected in the reality of practice. This is for a number of reasons including: large and complex problems; neglected workforce and infrastructure; inadequate training programmes; funding directed to bio-medical research and the role of vested interests.⁹

A crucial observation with regard to all of the proposed definitions of Public Health is that they not only provide a descriptive demarcation of what practices are to count as Public Health, but also hold out normative criteria, typically in the form of aims or goals that Public Health is said to necessarily strive for. In the past, this has been unproblematic, since there has been sufficient consensus on what these goals should be. However, different nations in fact formulate very different overarching goals for their respective Public Health policies. In many cases, the traditional goal of improving the health of the population is still paramount. However, in several countries, an equality-oriented goal has been formulated as well, focusing not so much on the entire population, but on certain segments of the population that are worse off with regard to health, and it is not given that spending Public Health resources for improving the health of this segment will be optimal for improving the health of the entire population. Moreover, in a few countries, like Sweden, the official goal of Public Health is no longer formulated in terms of improving population health, but rather in terms of providing the citizens with equal societal preconditions for attaining good health. Besides the element of an equality-oriented aim, this goal exchanges the aim of actually improving population health with societal means with the aim providing people with opportunities for attaining good health – opportunities which they may choose not to make use of.

In addition to this, the project has also revealed that different member states seem to have very different views on what sectors of societal practices are seen as connected to public

health. In some countries, the demarcation is rather narrow - focusing mainly on sectors directly involved in or closely related to health care – while in other cases, every societal endeavour is explicitly seen as having a relation to Public Health practice.

In light of this development, the EuroPHEN project has made two methodological operational choices. First, Public Health practices have been identified not on the basis of having an aim to improve population health, but having the aim of attaining some state with regard to population health seen as desirable within the society in question. In that way, countries pursuing societal activities with regard to population health which are not said to aim simply for improvement of this health can nevertheless be said to pursue a practice of Public Health. Second, when specifying the range of practices that have to be involved in order for a Public Health practice to be in place, great flexibility has been applied in order not to exclude any country on the mere basis of definition.

The first of these methodological choices has two further fruitful implications. First, since it separates the issue of what *Public Health is* and what *Public Health should be aiming for*, it makes possible ethical reflection with regard to Public Health without having this conflated with a terminological discussion. Thus, it becomes possible to say that in all European countries there are Public Health practices, but differing views on what they are for, and what ethical restrictions should be applied to them. Which of these latter views are the more plausible ones, and how they differ in relation to more basic ethical positions, can then be discussed as a straightforward ethical issue. Second, from the perspective of European harmonisation, this makes possible the perspective that, although different countries aim for different things and apply different restrictions within their respective Public Health practices, they have in common that they all have such practices. Thus, the political process can concentrate on finding a common enough basis of political and ethical values and norms for reaching the desired level of harmonisation, while permitting variations between countries with regard to what actual activities are pursued within Public Health.

2 Clinical Ethics Frameworks

Formal and informal professional codes of ethics exist in most countries (Appendix 1). These ethical standards have tended to concentrate on the micro level, focusing on the morality of interactions between individuals, such as doctor and patient. However, there has been less attention on the macro level ethics, on the tension between private and public interest.

2.1 Respect for human life

A number of the Codes require health professionals “*to show respect for human life*”.¹⁰ The Norwegian code¹¹ requires doctors to cherish human health, respect human rights, truth and justice in relation to the patient and society. Given the history during the 1930s and 1940s of medical experiments and abuse conducted by doctors in Germany, it is not surprising that the German code¹² requires doctors to respect all human life beginning with conception with reverence, and not use medical skills in contradiction to the laws of humanity, not even when under threat. The Polish code¹³ states that a physician’s vocation is the “*protection of human life and health, the prevention of disease, the treatment of patients and the relief of suffering*”. However, even in countries without a Fascist or Communist past, the professional codes can stress the importance of independence. For example in Ireland “*medical care must not be used as a tool of the State, or be granted or withheld or altered in character under political pressure*”.¹⁴

2.2 Putting the patient first

In many countries, for example in Germany¹², it is explicitly stated that the preservation and restoration of the patients’ health shall be the paramount obligation. In Poland, “*the physician’s ethical imperative is the good of the patient*”¹³, and in the UK, doctors must make the care of their patient their first concern. Irish doctors should “*do their best to preserve life and promote health*”.¹⁴ The goal for Norwegian doctors¹¹ is to heal, ease and comfort and to help the ill to regain their health and the healthy to preserve theirs. They must also look after the single patient interests and integrity.

Respect and dignity for patients underlie clinical practice. In Poland “*the physician should treat his/her patients with consideration and courtesy and show due respect for their personal dignity and privacy*”.¹³ UK doctors must “*treat every patient politely and considerately*”, “*respect patients’ dignity and privacy*” and “*listen to patients and respect their views*”. Nurses in the UK¹⁵ are also expected to respect the patient or client as an individual. Irish doctors¹⁴ should always treat patients with dignity and respect, and rude and insensitive behaviour towards patients or their relatives is unacceptable. Norwegian patients should be handled with warmth, caring and respect.¹¹ Working with the patient should be based on mutual trust and where it is possible build on informed agreement.

Many European Codes of conduct require that clinicians make the care of their patient their first concern. The obligation of a public health professional is to make the care of the population for which they are responsible their first concern. However, the various clinical codes are unreasonable in expecting a health professional doctor to make the care of each of

their patients their first concern, as these interests may conflict. A clinician may not have thousands or even millions of patients to care for, but they will certainly have more than one at a time, and even if it is something as basic as deciding which patient to see first, means that the care of one is being placed before that of another. Similarly, a public health professional cannot make the interests of every individual, there are just too many people, and there may be tensions between these interests. For example what the individual thinks is in his or her best interests may:

- be contrary to what others think is in the individual's best interests. Such policies could be described as being paternalistic. Children are a special case where parents and others may have conflicting views of the child's best interests;
- conflict with the best interests of one or more other identifiable individuals. Here public policy has an adjudication role and may consider what each individual *deserves* and duties of care;
- conflict with general societal interest i.e. interests of one or more individuals who are not identifiable or yet to be born. For example, arguments of justice might require a maximisation of return from scarce societal resources.

2.3 American codes of ethics

The American Medical Association (AMA) has adopted nine Principles of medical ethics (see Appendix).¹⁶ In the preamble to the Principles, the AMA observed that "*The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient*". The preamble goes on to state that "*a physician must recognize responsibility to patients first and foremost*". However, there is also a recognition that physicians have responsibilities "*to society, to other health professionals, and to self*". The Principles themselves share many features of codes of conduct for doctors in Europe and indeed other professional groups (for example the American Bar Association.¹⁷ Thus there is little merit in examining further the applicability of the AMA Code to public health.

2.4 American Principles of Public Health Ethics

However, the Public Health Leadership Society (PHLS) in the United States have developed Principles of the Ethical Practice of Public Health¹⁸, that may be of relevance to public health in Europe, or be of value in developing a Europe specific code of practice.

The use of the term *Public Health* can be very broad, making interpretation of the PHLS¹⁸ Principles problematic. The American PHLS¹⁸ principle 1 lays out the goals for public health as principally addressing "*the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes*" (P1). This is reinforced in principle 5 which refers to "*policies and programs that protect and promote health*" (P5). The guidance notes¹⁹ that accompany the Principles suggest that the Code is meant to cover the entire field of public health, including but not limited to government institutions and schools of public health. For a code to be useful it must include health promotion and not just disease prevention. It needs to address broader access and distributive issues. Probably poverty is the most important determinant of ill health. The problem is that it is difficult to use phrases such as "*we need to reduce poverty*" or to make reference to difficult population policies such as antenatal/neonatal screening or "*reducing population growth to create a healthy population*" without sounding glib or insensitive.

With the range of definitions described in Section 1 of this EuroPHEN report, a major difficulty is to define what is meant by public health or in the case of the PHLS Principles¹⁸, what is meant by the term *community health* (P2). Many of the Principles refer to community. For example: “*protect the confidentiality of information that can bring harm to an individual or community*” (P10); “*policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members*” (P3); “*provide communities with the information they have that is needed for decisions on policies or programs*” (P6); “*advocate and work for the empowerment of disenfranchised community members*” (P4), “*obtain the community’s consent*” (P6). The guidelines often refer to *community* as though it is a homogenous whole, although they do recognise that there are different cultures and disenfranchised members within the community.

For example, is it a healthy community in the sense of a group of individuals who live happily together to advance common goals. A community is made up of overlapping groups that can have special interests. The health of the population is the aggregation of the health of individuals even though there may be something more that is observed when people come together. Communities are in flux and always changing. Public health should strive to create an environment and structures that facilitate individual health, wellbeing and flourishing, and facilitate the interdependency between individuals necessary to achieve individual flourishing. Public health should achieve population health in a way that respects the rights of individuals and the interests and interdependencies of communities. By using a phrase such as “*public health should achieve community health in a way that respects the rights of individuals in the community*” the PHLS¹⁸ have slipped into using language of individual-focus bioethics.

2.5 Privacy and confidentiality

One of the most obvious ways that a clinician must demonstrate respect is in the context of privacy and consent. The German physician “*is bound to observe medical confidentiality. Information acquired by the physician in the course of his/her professional duties, concerning the patient and his/her background is confidential. The death of the patient does not release the physician from the duty of confidentiality.*”¹² In Poland¹³, doctors must also observe all confidential information, even beyond the patient’s death. In the UK nurses are required to “*protect confidential information*”¹⁵ and doctors must respect and protect confidential information.¹⁰ The Irish GMC¹⁴ states that “*Confidentiality is a time-honoured principle of medical ethics. It extends after death and is fundamental to the doctor/patient relationship*” The Irish GMC¹⁴ requires that the doctor must not disclose information to any person without the consent of the patient, unless ordered to do so by a Court or Tribunal or if disclosure was necessary to protect the interests of the patient, the welfare of society or of another individual or patient. Norwegian doctors¹¹ must preserve confidentiality and show discretions regarding those she/he lets know. The Norwegian regulating body¹¹ believes that the ethic for confidentiality should be more expansive than that which is provided for in law.

The American PHLS¹⁸ states that “*Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.*” The accompanying notes admit that the aims of this Principle are modest and that there are problems in defining the sorts of information being referred to. There is also no guidance on when disclosure would be appropriate. The PHLS guidance notes¹⁹ relate their

confidentiality Principle with the requirement that “*Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.*” In most countries, public health officials often do not have a mandate. They are employees of the State and are funded by taxes etc to carry out various functions. Thus they have responsibilities rather than a mandate.

2.6 Consent

UK nurses¹⁵ must obtain consent before giving any treatment or care. Giving information is also another important element of informed consent so UK doctors must give patients information in a way they can understand. Doctors in Ireland should, in general, ensure that a patient and family members, subject to patient consent, be as fully informed as possible about matters relating to an illness, and questions answered in non-technical terms. The requirement to obtain consent before a health professional gives any treatment or care is a very clinically orientated instruction. It is impossible to inform every member of a community of a public health decision, let alone obtain each person’s consent. The American PHLS guidance notes¹⁹ suggest that principle 6 of their Code is the community-level corollary of the individual-level ethical principle of informed consent. As a consequence, the community should be informed of the potential risks and benefits of the program etc. However, as the guidance notes admit, the principle does not specify how that consent should be obtained or discuss what community consent means. Does it mean active consent via referenda or passive consent demonstrated by a no or only a few letters of complaint or because there are no demonstrations in the street? There is unlikely to be a consensus and so there is the problem of what to do when there is dissent. There is a danger of a *tyranny of the majority* if a small or even a significant minority are ignored. However, there is also a risk of permitting a *tyranny of the minority*, if a small percentage of people are able to block a policy that it is in the wider interest. The need to consult and obtain consent is of less importance if public health policies are developed with and owned by the community.

2.7 Communication

Communicating with populations is much more difficult for a public health professional compared to listening and talking to a patient sitting with a doctor. On a one-to-one basis a doctor can tailor the amount and format of information according to the needs of the patient. At a population level this is much more difficult as there is immediate feedback. Population communication strategies need to be comprehensive to meet the very different needs of all members of the population. Public consultations need to be sophisticated to ensure that the views of as many people as possible in the population are listened to, not just those more skilled in lobbying or in more powerful positions.

Many of the PHLS Principles¹⁸ stress the importance of involving the public to encourage public ownership. It is easier to implement a policy if the policy is owned by the public. Public health professionals need to understand what a reasonable person would think. This comes from a collaborative ethos, in a meaningful way, rather than paying lip-service to consultation, or out of political correctness. The means of obtaining this input should be grounded in the needs of the public, embedded within the community itself. Sometimes the process needs to be proactive, sometimes reactive. The responses that you get from consultation will significantly depend on who is approached. People with vested interests are

more likely to respond, but they will also be better informed about the issues. Some times there is a need to consult with *ordinary* people sometime community representatives.

The responses obtained from public consultation may sometimes be ignored because they are not what was expected (or hoped for). However, this may be due to providing insufficient information and prejudice (or asking the wrong questions, or the wrong people, with the wrong methodology).

People should feel part of a society so that they can make a contribution to society. Public health has a role in helping to achieve this. Health care should be equally accessible to people of equal need. Reducing inequalities is worthwhile in its own right. It is not possible to ensure that health and a natural good should be equally distributed because of genetic inequality etc.

People need to know service exists and barriers to accessing these services should be minimised. The process of informing the public about their rights and responsibilities as a citizen is a process that is lifelong, starting with school education.

Identifying disenfranchised members of society is difficult because by definition they tend to be invisible and inaudible. They may not want to be identified because they think society is not relevant to them.

If a policy is worthwhile then it would be unjust not to know that it is worthwhile and how it should be best implemented

Public health policy should be implemented in a transparent manner that facilitates accountability, including the provision of all information and evidence used to inform the decision making process.

2.8 Discrimination and respect for diversity

The UK medical code requires that “*In all these matters you must never discriminate unfairly against your patients or colleagues*” and that personal beliefs do not prejudice patient care. In Germany¹² doctors are also required to ensure that they do not discriminate between religion, nationality, race, political affiliation, or social position. The Irish code¹⁴ requires that doctors “*must practise without consideration of religion, nationality, gender, race, ethnicity, age, politics, socio-economic grouping or patient disability.*” The Irish guide¹⁴ also says that “*treatment must never be refused on grounds of moral disapproval of the patient’s behaviour.*”

Requirements, for example with the PHLS Code¹⁸, to respect “*diverse values, beliefs and cultures*” while important to facilitate ownership and acceptance of a policy, does not mean that they have to act on views expressed. However there is a need to recognise diverse values.

The PHLS accompanying notes¹⁹ state that types of diversity, such as culture and gender, were intentionally not mentioned as any list would be arbitrary and inadequate. It is true that it would be difficult to produce such a list, but without such detail, recommendations have reduced utility.

2.9 Professional responsibility

As the UK GMC¹⁰ states, a doctor must always be prepared to justify their actions. Many of the professional codes stress the importance of behaving in a proper manner so as not to bring the profession into disrespect. For example, the German code¹² requires that doctors will preserve the honour and noble tradition of the medical profession to the best of their ability, exercise their profession scrupulously and with dignity and also protect the freedom and reputation of the medical profession. The UK medical code¹⁰ is more explicit about the requirement to identify and report unprofessional behaviour by acting quickly to protect patients from risk where there is good reason to believe that “*you or a colleague may not be fit to practise*”. Similarly in Ireland, where risk to a patient exists in relation to a colleague’s conduct or competence, doctors should express their concern to the colleague concerned in the first instance, followed by local systems and then if necessary reporting to the Medical Council.

In Norway¹¹, if a doctor has concerns about a fellow worker e.g. that they are ill or misusing drugs, they are also told to first raise this directly with their colleague. Care should be taken especially with medical students and junior doctors. If this does not solve the matter, the Norwegian doctors¹¹ should take the matter up with the administrator’s superior or the health authority. An onus is also placed on doctors to take care of their own health and seek help if it is needed.

The relationship with colleagues is important when defining what it means to be a professional, in terms of teamwork, training, and maintaining professional standards. UK nurses must co-operate with others in the team. German doctors¹² must pay respect to their teachers and colleagues. UK doctors¹⁰ should work with colleagues in the ways that best serve patients’ interests. The Irish guide¹⁴ suggests that doctors should give professional support to each other and that denigration of a colleague is never in the interests of patients and should be avoided. In Norway¹¹, doctors are also warned to be careful when criticising colleagues especially in front of patients and others, but they are also reminded that they must always have the patient’s best interests at heart.

Self regulation is an important criterion for the definition of a profession. The Irish guide¹⁴ to ethical conduct and behaviour defines misconduct in terms of what other colleagues expect. Thus misconduct is considered to be:

- “(a) Conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable; and /or
- (b) Conduct connected with his or her profession in which the doctor concerned has seriously fallen short by omission or commission of the standards of conduct expected among doctors.”

Another characteristic of a profession is the maintenance of “*professional knowledge and competence*”.¹⁵ The Polish code states that “*It comes within duties of each physician to constantly supplement and improve his/her professional knowledge and skills as well as to share own experience and skills with other fellow-physicians.*”¹³ Similarly in Norway¹¹, doctors are instructed to maintain their knowledge and seek to improve it. Public health specialists would share concerns about professional standards in terms of training and maintaining professional competency.

The PHLS Principles¹⁸ refer to the main skills, processes and activity used by public health professionals such as seeking “*the information needed to implement effective policies and*

programs”(P5) and engaging “*in collaborations and affiliations*” (P12). Acting in “*a timely manner*” (P7) on this information, and maintaining professional competence (P11) are also required, which are competencies that would be expected within any professional code of ethics.

The PHLS guidance notes¹⁹ for principle 11 suggest that the criteria for professional competence would have to be specified by individual professions, such as epidemiology and health education. As with the various professional codes of conducts for clinicians, professional competence is key if a public health professional is to do their role, but also to effectively work with other stakeholders, including those within the general public. However, as various professional bodies have discovered, designing a system to facilitate and monitor these competences can be complex and is often bureaucratic.

2.10 Trust

The German code¹² also refers to the importance of maintaining and enhancing confidence between physicians and patients. This issue is also prominent in the UK, where doctors¹⁰ are required to “*be trustworthy*”. The UK nursing code¹⁵ is explicit about the link between acting as a responsible professional and trust: “*Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care. avoid abusing your position as a doctor.*” In Ireland, it is recognised that “*the position of trust and privilege held by doctors in the community is founded not only on technical knowledge and skill, but also on high standards of personal and professional behaviour at all times.*”

Maintaining trust is a recurrent theme throughout the PHLS guidelines.¹⁸ For example, the accompanying text for P12 specifically refers to *conflicts of interests* undermining public trust. As with doctors and nurses, public health professionals must also be trustworthy, although the degree of dependence of an individual patient’s life, let alone that of a healthy member of the general public, on the actions of a public health professional is of course less. There should be trust in a public health professional to protect and promote the well-being of the population as a whole. However, this trust has been eroded by various public health scares and scandals, e.g. Bovine Spongiform Encephalopathy(BSE)/ new variant Creutzfeldt-Jakob Disease (CJD), and the combined measles, mumps and rubella (MMR) vaccination.

Public health professionals will have personal beliefs too, as with clinical decision making, these will always be there at a sub-conscious level, but as far as is practicable should not prejudice decision making.

Requirements to treat people with respect and consideration for dignity, privacy etc would apply at a population level too. Of course, respect for dignity and integrity does not mean that a public health professional must do everything that an individual or even what the majority of a population may want, just that their interests should be considered along with the interests of other individuals and groups in the population. All data and information should be respected as confidential, but as at an individual patient level, there may be circumstances when public interest requires that confidentiality should be broken. In such circumstances care must be taken to restrict the breach of confidence to ensure that there really is a genuine public interest requirement and that only the minimum amount of information is disclosed to appropriate third parties, who are also aware of their obligations.

2.11 Managing risk

UK nurses are instructed to “*act to identify and minimise risk to patients and clients.*”¹⁵ Public health professionals are continually managing risk, and hence it is appropriate to expect them to identify and minimise risks for a population, just as clinicians are required to minimise risk to patients and clients. However it is impossible to reduce all risk, and the risk for some may increase, in the same way that the interests of a few individuals may be impaired by policy that is in the general societal interest.

The intention behind PHLS Principle 9 is unclear: “*Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.*”¹⁸ It is certainly true that the physical environment can impact upon the social environment and vice versa, and the individual interacts with both forms of environment. Indeed the associated notes for this principle attempts to explain that “*this Principle stems from the assumptions of interdependence among people, and between people and their physical environment*”. Conflating physical and social environment within this recommendation adds additional complexity. Indeed even the term *physical environment* is multi faceted and could cover both the natural and man-made built environment. The notes go on to explain that “*it is like the ethical principle from medicine, ‘do no harm’, but it is worded in a positive way*”. The PHLS¹⁸ may therefore be referring to the Precautionary Principle, although there are subtle but important differences in the ways that the Precautionary Principle is interpreted in North America compared with Europe. It may be an overstatement to say that Public Health policy must enhance the physical environment but there should be an obligation to consider environmental impact.

2.12 Prioritisation and evidenced-based health care

The Norwegian Code¹¹ does refer to the need for interventions to be evidenced based. A doctor shall, by examination and treatment only use those methods which are recognised as acceptable. Methods which put the patient in danger must not be allowed.

The various European clinical regulatory organisations may have in mind a requirement to think about providing the best care to treat a patient’s disease rather than consider the cost implications. The Norwegian code¹¹ was slightly different as it states that a doctor should take in account the economic state of the society when making treatment decisions. The Code says that methods which are unnecessary or over costly should not be used. However, the Code goes on to say that a doctor must not in any way seek to punish single patients or groups with economic burdens, or prioritise. If there is a lack of resources in the doctor’s own work area then they should make these known. While, it is reasonable for a doctor to point out unmet need, it is sometimes difficult to reconcile directives to always prioritise patient care, without considering what implications the cost of a particular treatment may have on the budget available for other patients. The Polish code alluded to scarcity of resources, requiring physicians to “*perform all diagnostic, therapeutic and preventive procedures with due exactitude and appropriate allocation of time*”.¹³ The Irish guide is more explicit: “*Funds for healthcare are limited. A decision to spend money in one area may involve not having it available in another. The Council considers that doctors have a place in helping to ensure the efficient and effective use of resources and in giving advice on their allocation. Lack of*

*facilities does not excuse failure to help patients. Doctors have an obligation to point out deficiencies to the appropriate authorities and should not yield to pressures for cost savings if it means acting against the interests of patients.”*¹⁴

Equity is another important goal of public health, and hence American PHLS¹⁸ stresses that Public Health should strive to secure “*basic resources and conditions necessary for health are accessible to all*” (P4). Of course within the American health care system where a significant minority of the population are without health care coverage, this would be a major challenge. Public health agencies in the USA are relatively weak and have limited scope for influencing how and where money is spent within clinical care settings

For a public health professional, prioritisation and resource allocation decisions are a daily reality. Within public health practice it is impossible to avoid making choices between people. At a population level discrimination is required when making prioritisation decisions based on capacity to benefit, cost-effectiveness etc. Sometimes public health professionals become involved in making decisions, when they must discriminate between the interests of individuals, e.g. in communicable disease control. However, the important ethical issue is that this discrimination is fair and equitable. Similarly situated individuals should have equal access to health care services. Where one individual or group has greater capacity to benefit or more people may benefit because an intervention is more cost-effective compared to another, then it is just, indeed ethically required, to make such choices.

Most European Member States have financial restrictions on their health budgets. However, when a healthcare system is struggling to constrain costs, it is even more important to have a clear ethical normative framework and an explicit set of human values against which to prioritise requests for health care. It is also important that public health professionals do not lose sight of the need to understand how *disease* is related to *suffering*. Thus public health policy should be dependent on a medical model of health. The implicit debate as to why public health should be focused on the need to increase health and well being, should be made explicit. There is a reductionist tendency of public health as a discipline to medicalise the health of the public. For example, public health professionals seem *insistent* on making people live as long as possible, irrespective of the consequences on quality of life. Public health professionals do recognise the importance of quality of life and hence should add life to years as well as years to life. However, they tend to have a more restrictive concept of the *Good Life* and hence have difficulty recognising that people truly are able to have a better quality of life when undertaking *unhealthy behaviours*. Thus not only are smokers likely to have a shorter life expectancy, legislative frameworks and social cultures of stigma and blame may mean that they have reduced quality as well as quantity of life.

3 The EuroPHEN Project

3.1 The Rationale for EuroPHEN

Under the Treaty on European Union, the European Community was given a competence in public health. Article 3(o) of the Treaty establishes a broad aim of making “*a contribution to the attainment of a high level of health protection*”. Article 129 specifies that this is to be achieved by the encouragement of co-operation between the Member States and, if necessary, the provision of support to their action; the promotion of co-ordination of policies and programmes of the Member States; and the fostering of co-operation with third countries and the competent international organisations in the sphere of public health.

Within the descriptive summary of the Treaty on European Union²⁰, “*threats to the public health*” was identified as one of the “*daunting array of challenges*” faced by a European Union at the threshold of the 21st century. Whilst recognising that these threats had to be confronted “*at a time when political institutions everywhere are under question by an increasingly well-informed public*”, it was also recognised that in the light of recent public health scares, people want a high level of health protection. The Treaty underscored that a high level of human health protection will be ensured in the definition and implementation of all Community policies and activities. In fact, Directorate General Health and Consumer Protection (DG SANCO), had as its mission “*to ensure a high level of protection of consumers*” health, safety and economic interests as well as of public health at the level of the European Union. As a result, Community Action will be directed towards improving public health, preventing human illness or diseases and obviating sources of danger to human health. The priorities in the “*Proposal for a programme of Community action in the field of public health (2001-2006)*”²¹ emphasised the Community’s broad health strategy for the future and how it should work to “*achieve a coherent and effect approach to health issues across all the different policy areas*”. A key element of this was a new public health framework to enable the Community to respond more effectively to its obligations by setting out clear objectives and policy instruments.

Different cultures will give different moral weight to protecting individual interests versus action for collective benefit. Deriving international public health policy will be problematic if communities within particular countries do not share the same moral values. It is unlikely that gross differences will exist within the European Union, although there is likely to be more scope for variance with expansion of the European Union. However, even subtle differences in moral preferences may cause problems in deriving public health policy within the European Union.

Beagle and Bonita² recognised that international comparisons of national health systems have focused on the organisation and delivery of personal medical care services. In contrast, there have been few comparable studies focusing on public health systems. From a research perspective, they thought that it would be desirable to assess all aspects of national public health institutions and organisations, including central and local governmental and non-governmental organisations, the capacity of the entire public health work-force and the priority given to public health policies in order to categorise national public health systems and relate these to measures of health status of populations. They concluded that “*unfortunately, the data required for such a formal assessment are not available*”.

An evaluation¹⁰ of five infectious disease outbreaks, with various transmission routes, involving more than one Member State, identified critical weaknesses in co-ordination, funding and reporting. The authors recommended that the European Commission further develop existing disease-related surveillance networks. They further commented that *“this will need to be done within a framework in which organisational, financial, and legal uncertainties are clarified”*. If the co-ordinated approach that they and others¹¹ recommend is to be successful it will be important to understand the philosophy underpinning the various national approaches to communicable disease control.

As Van der Werff has pointed out: comparative studies may *“get no further than a ‘description’ and ‘explanation’ of the similarities and the differences; the effectiveness and efficiency of particular public health approaches may not be identified and measured”*.¹² He went on to say that *“comparative analysis has proven to be a creative source of information on the application of public health approaches across countries... when public health approaches are compared, it is essential to make sure that the situational context of each of the compared approaches is carefully analysed and well understood before conclusions are drawn”*. Van der Werff recognised that *“the health system in any country is part of its social and political setting. Different ideologies, norms and values are at the roots of the position placed by society on health, the choices made with respect to the balance between collectivism and individualism, and the decisions taken on the degree of equity in the distribution of services and resources”*.

The need to conduct international comparative assessments of public health policy was also recognised by Detels *et al.*: *“The magnitude and success of public health efforts will vary both in time and place in different areas of the world. Nevertheless, the principles of public health remain the same. The actions which should be taken are determined by the nature and magnitude of the problems affecting the health of the community. What can be done will be determined by the scientific knowledge and resources available. What is done will be determined by the social and political commitment existing at the particular time and place.”*¹³

In 1998, the *Société Française de Santé Publique* performed a survey on behalf of the European Commission (Employment and Social affairs) to determine the views of European public health professionals on priorities for action in public health within Europe.¹⁴ In each Member State (except Luxembourg) the *Société* identified a representative of one of the national public health associations. These representatives were asked to collect the views of at least 30 of their members, representing as far as possible differing roles and strands of opinion within public health. Public health specialists were asked to identify priorities for EU action (Table 1). They were asked to base their choices on four criteria:

- An emergent issue in one or more countries which could become a major public health problem at a European level;
- A public health problem existing in several or all countries of the European Union;
- A public health problem for which action by the EU could contribute to convergence of national or local policies, with beneficial consequences;
- A subject where community action would produce a more effective response than national or local ones alone.

A very large number of topics were proposed. The 76 French respondents for example, cited 250 separate issues. Many respondents stressed issues of particular importance in their own

countries or regions. For example accidents were given greater prominence by Greece, Spain and Portugal than by northern European countries.

Table 1: Two most frequently cited priorities from each country (where priorities were ranked)

| Country | Top two priorities |
|-----------------|--|
| Austria | Health promotion; Re-orientation of health care systems |
| Denmark | Environmental health; Tobacco |
| Finland | Illegal narcotic drugs; use of alcohol |
| France | Increase of inequalities in health status and in health care accessibility; Health impact of environment damage |
| Germany | Inequality and health; Ageing and health |
| Ireland | Car accidents (and other accidents); Drugs |
| The Netherlands | Lifestyle, including addiction (drugs, tobacco, alcohol); Chronic illness (including ageing) |
| Portugal | Communicable diseases; Addiction |
| Spain | Social inequalities and health; Control of tobacco, alcohol and drugs |
| Sweden | Inequality in health; Care of the elderly |
| UK | Tobacco; Inequalities |

There was also considerable variation in the way in which issues were categorised. The authors of the report believed that *“these were not simply chance differences and appeared to reflect firmly held national differences as to how various issues were regarded”*. Weil and McKee¹⁵ believed that the survey had demonstrated that *“achieving consensus”* on priorities among public health professionals at a European level is not easy. As has been shown with clinical medicine, natural cultural factors are important in how issues are interpreted so that detailed discussion at a European level is constrained by differing understandings of common terminology. The report concluded that, *“public health in Europe is extremely heterogeneous. This diversity gives public health at a European level strengths and weaknesses. A strength is the diversity that provides many different perspectives from which one can see an issue, as well as providing a wealth of different approaches to common problems. A weakness has long been the difficulty in this diverse community speaking with a single voice”*.

Hutt specified five moral imperatives of government for its regulatory process: to protect the public from harm; to preserve maximum individual choice; to guarantee meaningful public participation in the decision-making process; to promote consistent and dependable rules applicable to everyone and to provide prompt decisions on all issues that arise in a regulatory context.¹⁶ One of the challenges for public policy is to reconcile the potential conflict between the first two of these imperatives. Douglas Weed argued that philosophical perspectives underlie and influence complex decisions in public health but are rarely described by decision makers. He believed that ethics seems particularly relevant to public health since decision making entails balancing benefits and risks to individuals and to society. He went on to suggest that *“If public health professionals embrace the need to examine and proclaim their philosophical foundation, then a guide encompassing ethics, ontology, and epistemology is needed. Call it a guide to the philosophy of public health.”*¹⁷

Weed proposed a three stage process for deriving a philosophy of public health. *“In the first phase ... practitioners would use a philosophical idea to illuminate an issue in the practice of public health. Philosophers in turn would use a public health problem to illustrate some*

aspect of philosophy... In the second phase... more formal philosophical analyses would be applied to problems that comprise the 'matter' of public health ... In the final phase, a philosophy of public health would emerge from an examination of the discipline itself as a discipline. A philosophy of public health would consist of a general theory of public health in which the problems examined and solutions proposed in the previous phases would be incorporated and synthesised."

Some elements of the work packages of EuroPHEN could have been conducted at a national level, but there are a number of reasons why the project should have been conducted at a European level. For example, the challenge of developing a framework for public health ethics is common to all Member States, and economy of scale and effort will allow them all to benefit from the involvement of ethics and public health experts from across Europe. Research conducted at a European level is more likely to provide information to Member States on the views of all their ethnic communities of European origin.

3.2 Normative Ethics

One of the classical questions of philosophy, and the central question of moral philosophy, is *how should one live?* Variations on this question are *what I do with me life?* *What I make of myself?* *What kind of person I become?* These questions are of importance to all of us, although few people normally reflect on them in depth, and if we do, only on rare occasions. Moral philosophy, however, attempts to answer the question of *how one should live*. Moral philosophy can be divided into three basic disciplines: *normative ethics*, *applied ethics* and *metaethics*. *Normative ethics* provides substantive proposals as to how live, how to act, what sort of person one should be. In particular, it attempts to provide a moral framework governing these principles, in terms of what is right and wrong and in turn to specify associated rights and duties etc.. Much of philosophical argument within normative ethics revolves around whether there is a single moral principles from which all other moral principles can be derived, or perhaps a comprehensive list of basic moral principles, or at least a list of the most important principles. The language of *principles* is more appropriate than that of *rules*, although some normative theories do construct arguments for rules that apply for the *entire universe for now and all time*.

Since such basic moral principles will probably be stated in more general terms, it may not be clear as what should be done in a particular case, especially in morally complex situations. This is more likely within a normative framework derived from several fundamental principles which conflict or appear to conflict. However, it may even be difficult to assess how one fundamental principle should be applied in a particularly controversial issue. *Applied ethics* is therefore the branch of moral philosophy that seeks to apply the general principles of *normative ethics* to such complex problems. Not surprisingly, the moral judgements offered within *applied ethics* can be particularly controversial, e.g. in the context of abortion, euthanasia, capital punishment etc. *Normative ethics*, and in turn, *applied ethics* are only *guides* in helping to answer moral decisions about whether a particular mother should have an abortion, a particular patient should be assisted to die or a particular murder should be executed. The distinction between each stage of considering the *normative*, the *applied* and the *particular* is blurred, and more of a continuum from the generality to the specific. *Metaethics* deals with more of the process of how to address moral problems, rather than their solution. Although such considerations are important in assisting the concerns of *normative* and *applied ethics*. For example, when a claim is made that an action is *wrong*, what exactly

does *wrong* mean? When weighing considerations and claims, what *facts* are relevant to take into account, and how is such *knowledge* derived. Such questions address the *nature* rather than the *content* of morality.

The EuroPHEN project is primarily concerned with *normative ethics*. It is *applied* in the sense of application to the field of Public Health. But it aims to ask address the question *How should one practice as a Public Health Professional?* (as opposed to *how should one live?*). As with the higher level question, there will be associated *normative* questions such as *What are the priorities for Public Health? How should policy be derived? Who should be involved? How should policy be implemented?* As before, there is a continuum, into more *applied* situations in relation to specific public health policy areas such as tobacco consumption reduction, drug control, communicable diseases. EuroPHEN will explore such specific policy areas too, however, the focus remains to addressing the *normative* issues relating to public health practice.

The rival *normative* theories explored within EuroPHEN address how people *ought* to act, morally speaking. They are not claims about how people *do* act. EuroPHEN has also explored how public policy makers *act* by describing the legislation and policies that they have developed and seek to implement. EuroPHEN also explored how citizens respond to these specific policies. However, it is important to be clear about the distinction between *what ought to be* and *what is*. A claim about how people/professionals *ought to act* should not be mistaken for a description of how people/professionals *actually act*. The importance of this distinction is that it is not possible to disprove an assertion as to what *ought* to be done in a particular circumstance just by producing evidence demonstrating that people/professionals *do not act* in this way. Descriptions of the way people do behave are of relevance to ethics. *Empirical* claims may be relevant to defending *ethical* claims, but is important to remember that the two sorts of claim are qualitatively different.

EuroPHEN also explored clinical professional codes of ethics in various countries. However, it is also important to distinguish substantive moral claims of *normative* ethics with mere descriptions of the moral beliefs or ethical codes of some group or organisation. These codes may have legal or quasi legal standing, for example in regulating professional behaviour, but they are frequently derived by committees of professionals with limited or no ethics training or input from philosophers. This is not to say that such codes do not have value, indeed may have moral value. However, there is a distinction between how a particular body *thinks* its members should act, as opposed to how they *really* should act. The fact that someone makes a moral claim does not necessarily mean that it is morally correct. Just as the earth is not flat because someone says that it is. It is also necessary to distinguish to moral from the legal. Just because the law permits or even requires that we act in a certain way, does not mean that such an act or omission is morally valid. For example, slavery was and killing (in terms of capital punishment) is still permitted in some countries. The study of how groups or societies think they should act is more properly within the domain of sociologist, historians or anthropologists, rather than philosophers. The study of the moral beliefs of different cultures does demonstrate that societies have disagreed about moral problems and disagreements between protagonists of conflicting positions can help in highlighting strengths and weakness or moral arguments. However, it is likely that difference in professional codes, legislation, policy etc between European Member States is likely to represent historical and epidemiological differences, rather than fundamental differences in what is held to be morally correct in one country compared to another.

3.3 *EuroPHEN Aim and Objectives*

3.3.1 Aim

To derive a framework for producing common approaches to public health policy across the European Union by examining concepts of European and universal ethical standards by conducting work in three areas:

- Public health policy and practice;
- Ethical analysis;
- Empirical research on public attitudes.

3.3.2 Objectives

1. To compare and contrast organisation of public health structures in Member States.
2. To compare and contrast the priority lists identified within Member States.
3. To compare and contrast public policy responses to selected public health problems in Member States and to examine how public policy in different countries weigh competing claims of private and public interest.
4. To identify ethical issues that may arise from tensions between the private and public interest and to analyse these tensions in the context of various ethical theories, principles and traditions.
5. To identify the elements or characteristics of a public policy programme that influence when and why societal intervention is or is not appropriate.
6. To examine how citizens in different countries and cultures weigh competing claims of private and public interest and view the appropriateness of public health intervention at national or European level.
7. To understand the implications of any differences between Member States in priority given to individual and public interests when attempting to devise international law for public health problems that cross national boundaries.
8. To assess the feasibility and desirability of common approaches to public health within the European Union and internationally within universal ethical standards.
9. Dissemination of project findings to inform policy makers within Member States and European Institutions when discharging their public health responsibilities with national legislation and the Treaty on European Union.
10. To put in place project management arrangements to ensure that European funding is used prudently and that the project produces the promised outputs.

4 Philosophical Theories

4.1 *Social justice and deliberative democracy*

Decision-making is a process that is innate to both practicing medicine and running a professional practice. This process can affect the community as a whole, since it involves decisions concerning resource distribution and therefore the patients, as the progress of their illness can be altered. The majority of the decisions made are quite complex. In the resource distribution processes, on a macro-level, the complexity lies in the finite nature of these resources, and so priorities need to be established. So, when resources are channelled towards a certain illness or patient group, they are taken away from the care of other patients or illnesses. Economists define this concept as *opportunity cost*. This concept refers to the costs attributable to the financing possibilities that have been foregone in the distribution of the resources toward other demands or needs due to established priorities. This also includes the Pareto efficiency concept, according to which, the good that results from the allocation of resources to a specific area should outweigh the bad that is produced in the areas where they have not been allocated.²² In other words, the measurement of efficiency in the distribution in health resources distribution involves an opportunity cost assessment of that decision and, therefore, a cost comparison of the various opportunities that are in the need of these resources.

From a philosophical viewpoint, the efficiency concept is based on utilitarianism, whose utilitarian rule promotes pursuing the greatest good for the greatest number for people as a moral basis in decision-making regarding resource distribution.²³ Therefore, utilitarianism bases its decisions on the application of the cost-benefit analysis, which, in the realm of health decisions, takes on the forms of cost-effectiveness analysis and cost-utility analysis. Utilitarianism critics maintain that, as a social justice theory, it does not completely respond to the Aristotelian maxim of *treat equals equally and unequals unequally*. Thus, the utilitarian rule could assign the resources intended for unequal needs in an egalitarian manner. In other words, utilitarianism would penalise the assigning of resources to those illnesses that were not very prevalent, where the decision would result in only a slight improvement or where many people would have to be treated only to gain a very small number of successes. For the purpose of correcting these potential limitations of utilitarianism, other authors propose egalitarian liberalism, whose main advocate was John Rawls.²⁴ This theory of justice considers the inequality of opportunities and promotes the so-called, in public policies, positive discrimination strategies as a way to correct them. Rawls' approach has been the object of many moral philosophy reviews, grouped under the concept of social justice theories.²⁵ Some authors have proposed the application of these social justice theories to health resources distribution. Finally, the liberal libertarian theories propose that it is the market that should promote a fair distribution of health resources, through the laws of supply and demand. These three great social justice theories are complemented with theories that emphasise the procedure that accompanies decision-making and, more specifically, the democratisation of the decision through the incorporation of the preferences of those affected. Among these theories, communitarianism and republicanism are two worth mentioning. The latter obtained its name from the republican works of Cicero in ancient Rome.

The social justice theories mentioned determine the moral bases and, to a certain extent, the procedures in which the resource distribution decisions are made. The complexity of these decisions, nevertheless, often makes the application of these theories difficult. We have an

example of this complexity that arises during health resource distribution decision-making in the possible contradiction that is produced when having to join liberal egalitarianism, which stems in Spain from the General Health Law of 1986, with utilitarianism, which bases the cost-effectiveness analysis on that which certain health decisions are based. A second type of theory is proposed, for the purpose of resolving this type of ethical dilemma, which places greater emphasis on the procedures through which the decisions are made. Deliberative democracy, or democratic deliberation stands out among these types of theory due to its clarity. This theory originates from the tradition of Pericles of ancient Athens.²⁶ Deliberative democracy advocates are set apart, as they come from both the republican-communitarian and the liberal tradition, where the former seek consensus in obtaining the common good, while the latter seek recognition from the masses and, therefore, try to reach an agreement regarding the differences in the decision-making processes. Despite this differential nuance, democratic deliberation supports, from a moral standpoint, the adoption of the reciprocity principle in decision-making processes. In this way, deliberative democracy would constitute a form of governance in which the free and equal citizens and their representatives would justify their decisions through a process in which the reasons that are the basis for the decision would be exchanged. These reasons would be mutually accepted and the arguments upon which they were based would have to be accessible to the deliberating parties. The decisions that would be allowed would be those to which all would be committed to observe at the present time and to submit to further deliberation in the future.²⁷

4.1.1 Principles and criteria of deliberation democracy

Amy Gutmann and Dennis Thompson describe the principles that should meet deliberative democracy and the criteria that allows the assessment of its application in health decision-making.^{27 28} Among the deliberative democracy principles are: to facilitate the arguments of collective decisions, introduce different viewpoints to the issues that affect the public, promote decision processes based on mutual respect, and correct the misunderstandings associated with the incorrect interpretation of information or the absence thereof. According to these authors, the criteria that the health decisions should meet should be: accessible, moral, respectful and revisable. One example of a health decision recently made in Spain is that of the therapeutic visas or restrictions in the prescribing of specific drugs. This decision can be analysed according to the aforementioned four criteria of deliberative democracy. Using these criteria, it can be determined whether the moral positioning has been honoured, whereby the authorities should justify their decisions to those who are obligated to comply with them. In this way, the decisions are submitted to the principle of reciprocity.

According to the first criteria regarding accessibility, the decisions concerning therapeutic visas should be based on public accessible scientific arguments, easily understood by the citizens and professionals who must comply with them and approved by experts unaffiliated with the organisation making the decision. Thus, the decision concerning therapeutic visas would be considered accessible if it were submitted to public hearings and defended by the health authorities in front of patient representatives, doctors, health professionals, health service providers and the pharmaceutical and insurance industries. The moral criterion assumes the setting up of a deliberation forum in which all the agents or stakeholders involved would justify their position and views as regards the visa, done so for the common good and not in favour of their individual interests. Recently, one example of the variety of perspectives with which the visa's introduction can be contemplated has been described. These two criteria allow the supposition that if someone is convinced that their position is

just, responding in an adequate manner to the collective's needs, they should have no objection to defending it publicly and submitting it to public deliberation.

The third revision criterion, that of mutual respect, involves two facts. The first presumes the readiness to listen to and accept others' values and viewpoints. The second leads to the admission that another's moral position is as valid as one's own. Mutual respect is a moral attitude that does not have to lead to agreement between the parties. So, if, in fulfilling this criterion, the moral disagreement persists, Gutmann and Thompson propose seeking alternatives that, without eliminating the disagreement, reduce conflict and allow compromises to be reached. An attempt is made to economise the moral disagreements. In the case of the therapeutic visas application, the moral disagreement could be economised in different ways. These include those that are found in a prevalence study of the clinical conditions for which the medicines that are the object of the visa are indicated, an analysis of the health conditions for which they are being prescribed, more detailed information for doctors and patients as regards the circumstances and criteria for which these have been approved and the potential improvement in the health care for the patients affected by the visa, either through the patient associations cooperation or through improvements in specialised care accessibility. Some of these action plans could take place before the use of visa is implemented. The suitability of the visa could also be assessed through an analysis of the results obtained in terms of health outcomes.

Finally, the last criterion concerning decision assessment is that of revision or provisionality. Likewise, it is believed that the deliberation process should be reiterative and, thus, all decisions should periodically be submitted for review if they are to maintain fairness. In this way, a decision would be charged if new scientific evidence were to arise that changed the justifications and arguments that are the basis of the decision, or if the moral values or the context in which the decision was made were to change. With these four criteria, deliberative democracy adopts the principals of reciprocity and that of accountability as basic elements of the health decision making process.^{27 29}

4.2 Liberalism and Public Health

The question *what implications does liberalism have to public health policies?* entails different answers depending on the interpretation given to liberalism. Instead of being a unified doctrine, liberalism is a ramified set of ideas on liberty and individual autonomy. Some proponents of liberalism stress the value of economic liberty and the freedom of the markets and speak for hands-off policies, while others emphasise the first orderliness of negative individual rights. These, roughly defined disciples of classical liberals can be further divided in libertarians for whom all interference by the state is unjustifiable and in new conservatives who try to combine classical liberalism, its individualism and laissez-faire capitalism with what they see as not only justifiable but also necessary interference in moral issues.

Some conservatives want to enforce cultural unity and patriotism like Roger Scruton while some others, like John Gray, claim that a (classical) liberal society cannot guarantee the physical and moral wellbeing of all its members. In addition, and to make things more complicated, there are conservatives who embrace conservative values but keep calling themselves classical liberals – a prime example being David Conway who is convinced that growing crime rates are related to the collapse of two parent families and to the fact that welfare state has enabled young women to raise children without needing to be maintained by the fathers of these children – something a true liberal would hardly claim.³⁰ The problemacy of different interpretations of *liberalism* is obvious in his statement that “*the term ‘liberal’ has now come to stand in some countries, notably, the USA, for someone who supports egalitarian policies. The classical liberal view has some to be called ‘conservative’*”.³¹

The new conservatives have also joined ranks with communitarians in their critique of individual autonomy, which according to them, is valuable if and only if one’s personal choices promote good life, as they see it. But, to demand that autonomous choices fulfil certain inner criteria in order to be respected makes this stand necessarily anti-liberal, no matter how individualist and liberty-oriented they might be in economics. Milleian individualism and autonomy would, according to these conservatives, only hurt the community and its members by undermining what is good for people. This perfectionist, paternalistic and moralistic view is best depicted by quoting John Gray’s words: “*the conservative individualist, unlike the Milleian individualist, can have no objection to policies of legal prohibition of these sorts, where other measures are demonstrably ineffectual, and the activities proscribed pose a real threat to the values that sustain a liberal society*”.³²

“*Government has a legitimate interest in protecting us from self-harm, if only because there are few such harms that are not also harms to others. ...In the idiom of modern moral philosophy, government – and certainly conservative government – has good reason to undertake policies of paternalism and moralism, where these can expect a decent measure of success.*”³³

For Gray as well as for many who share similar views, there are choices that nobody in their right mind would make. And it is this keen interest in the *content* of our self-regarding choices, which makes it difficult to see them as sincere defenders of liberty – as they proclaim to be. How is it possible to simultaneously praise individual liberty and its first orderliness among values and claim that people be prohibited, if necessary by law, from making self-regarding choices which by *conservative* standards are unintelligible to more *rational* citizens.

This controversy also means that this kind of emphasis on liberty cannot be seen as a true representative of liberalism.

In addition to libertarians, we do have a variety of mainstream liberalists for whom individual autonomy is inviolable but who, unlike the libertarians, claim that human wellbeing requires a certain amount of positive rights and corresponding duties. Most often these liberalists are known as welfare or egalitarian liberalists and sometimes they are referred to as revisionist or modern liberalists, especially when seen as a counterpart for classical liberalists. They may be classified as deontologists or consequentialists or even rights emphasising but consequence sensitive (like Hart and Dworkin), the common nominator being that they all speak for individual autonomy in self-regarding matters and for state neutrality between different conceptions of good. Also, they value individuality, individual rights and freedom and a certain notion of equality, and their belief in rationality allow them to believe in social improvement in Enlightenment's spirit. According to them, state's role should be restricted to the prevention of harm, which may occur by actively harming people or, equally well, by not responding to their basic needs. John Stuart Mill already pointed out the importance of positive conditions such as education for the meaningful realisation of individual liberty. As Andrew Kernohan puts it: *"liberals do not take a stand on the truth or falsity of a person's beliefs about what constitutes the good life. That is the point of the liberal commitment to tolerance and the neutrality of the state. ...However, there is one ethical belief on which egalitarian liberals must make a stand: egalitarian liberals are committed to the equal moral worth of persons...The liberal state is to remain agnostic about the truth or falsity of different substantive conceptions of how to lead a good life."*³⁴

This is exactly what separates liberalism from conservatives and communitarians for whom the state should take an interest in what constitutes a good, bad or evil life. John Kekes, a conservative himself, has interpreted the difference quite rightly: *"The liberal intuition is that justice requires the recognition of the equal right of human beings to the resources they need for living autonomously. The contrary intuition is that justice makes the right to such resources contingent on what their recipients deserves. The liberal intuition is motivated by the egalitarian belief that at a fundamental level all human beings have equal worth. The contrary intuition is motivated by the antiegalitarian belief that the worth of human beings varies with their moral merits"*.³⁵

In public health as well as in other areas of public policies, Kekes and other conservatives want to ask the liberal authorities *"how could it be maintained that good and wicked people should be given the same amount of scarce resources?"* (p208).³⁵ For liberals themselves, the question is pointless since in equity's name, only two issues need assessment. Firstly, what people's basic needs (no matter how defined) are and secondly, whether we have reason to believe that those in need genuinely benefit from assistance.

4.2.1 What does liberty mean and why is it important?

Liberal thinkers have usually defined freedom either as the lack of constraints or as the ability of individuals to decide for themselves what happens in their lives.³⁶ Within the most classical forms of liberalism, *to say that people are free means primarily that they are not legally or otherwise coercively prevented from acting according to their desires and plans*. In practice this would mean, for instance that no one should be legally denied access to houses with sanitation or medical services on offer. This definition is, however, problematic since individuals are not always free, at least not according to everyday thinking, even if they are

not hindered from doing what they desire, or want to do. If my poverty forces me to live without sanitation or lack of medication kills me and my family, it might be misleading to praise my freedom.

On the other hand, the non-restriction of options and the capacity to make autonomous decisions have been seen as valuable in the liberal tradition. Some theorists have thought that the value of freedom is intrinsic and intuitively detectable to anybody. They think that it is symbolically important to individuals to know that there are more books in the nearby library than they are ever going to read, and more restaurants than they are ever going to visit.³⁷ These theorists may also believe that the freedom of choice exemplified by the books and dishes is somehow self-evidently valuable, and should in no way be restricted. There are, however, difficulties with this argument for freedom and its symbolic value. A wide range of choices can, of course, be symbolically exhilarating and personally satisfying but if this liberty seriously interferes with others' liberties, not to mention their welfare interests, egalitarian liberalists should be ready to consider restrictions of freedom. They should accept that some of the money meant for library books is spent, if politically so decided, in elderly care.

In a liberal welfare state, one of the major challenges is the constant bargaining about resources between different sectors of public services like education, health, social security, public works and within these particular sectors. This means that there may be major differences in views about the proportional importance of various preventive measures in matters concerning people's health. This constant battle for scarce resources has accentuated the need for efficiency in public services. Although efficiency is a necessary instrumental value in the provision of these services, it may easily become an all-encompassing value for the most market-oriented politicians. If this happens, concern for equality and individual autonomy quickly vanishes into thin air.

Other champions of liberty have argued that the value of freedom is instrumental rather than intrinsic. A society, they say, which does not unduly interfere with the choices of its members encourages their creativity, genius and industriousness.³⁸ These qualities are seen as valuable because they lay the foundation for material wellbeing and cultural flourishing in a society, and bring happiness to the nation as a whole. The flaw of this defence is that it cannot be supported by empirical proof. A better way to defend the value of freedom can, I think, be found. First, the value of freedom of action and choice is instrumental, and it is based on the fact that the non-restriction of a person's options is, to some degree at least, a necessary condition for autonomous decision-making. Second, autonomy and self-determination are valuable in themselves, since they belong to the primary elements of a good and happy human life. Material well-being is, no doubt, possible without liberty and autonomy, but whether or not such welfare is worth pursuing is another matter. The happiness and wellbeing that most ethical theories see as the highest goal of human life conceptually presupposes that individuals are free to decide what the direction of their life and their actions is.

According to the basic principles of Millian liberalism competent individuals are fully entitled to make choices which they themselves or others regard as irrational. Rationality and irrationality can be defined in many ways, but no morally neutral description can in and by itself legitimise the use of coercion on others. Besides, most forms of rationality are such that individuals cannot even in theory be forced to assume them. The consistency and realism of people's beliefs, which is sometimes seen as a hallmark of rationality, can be increased by

education but it can seldom be furthered by legal sanctions – Prohibition laws in the U.S. and in Finland in early 20th century pretty much prove the point.

Some moralists have challenged this strictly liberal view by arguing that irrational decisions are never autonomous: individuals who continuously make them should be likened to the mentally ill and the emotionally disturbed. The proponents of more moderate doctrines have suggested, accordingly, that choices which are not rational should be restricted on the grounds that they are not sufficiently self-determined. But seen from the Millian viewpoint this argument is skewed. When competent human beings make informed decisions without the coercive influence of others, the ensuing actions are autonomous in the relevant technical sense even when they can be depicted as self-destructive or silly.

4.2.2 Freedom and democracy

In a heterogeneous, pluralist society, it would be difficult to find ethical and political principles that everybody can both condone and understand in the same way. Hence it is not reasonable to see public health policies solely as part of political and democratic decision-making. Public health must be based on scientific research which gives essential background information about probabilities and causalities regarding possible health hazards. This information, however, is not normative. The fact that saturated animal fat is bad for our health does not mean that either sale or consumption should be prohibited because of this causal connection. In a liberal society, the information should be available for all and people encouraged to choose healthier alternatives but the final choice should be left to people themselves.

On one hand, in a democratic society, politics may dictate how resources are divided between and within different sectors of public services – whether for instance health education is seen as more important than cancer screening programs. What majority politics, on the other hand, cannot do is to use arbitrarily chosen criteria to determine who is included and excluded. Commitment to equality and impartiality means that it would be justifiable, in consideration of both scarce resources and empirical medical evidence, to exclude, for example those under thirty from free routine cholesterol check-ups. On the other hand it would not be justifiable to demand that citizens who are not committed to the use of vegetable oils, should pay for the tests themselves. Egalitarian, welfare liberalism requires that people are not discriminated against because of their economic situation, beliefs, values and what others might call their *moral worth*. Liberalism's tight connection to democratic decision-making does not in itself imply majority rule in issues that reflect on individual rights. Value neutrality demands that the authorities defend policies where antipaternalistic concept of liberty is combined with impartial concern for equally needy.

The most important question concerning the proper limits of individual liberty is whether public health policies and public health care respect enough people's own wishes and interests, and, at the same time, protect them from each other's conflicting choices, even if it sometimes means that people's preferences have to be laundered in order to achieve tolerance and reciprocal forbearance. If I am ready to participate in medical costs of clogged arteries, caused by indulgence in rich, unhealthy eating habits, an anti-smoking butter-and-eggs eater should be equally ready to participate in costs caused by smoking. In a liberal society public health authorities should promote autonomy-respecting health programs which ideally aim at rendering people aware of the conditions of their own health. What they are not allowed to do

is to find ways to manipulate, threaten or coerce people into *choosing* healthier life-styles, simply because manipulation, threat and coercion undermine individual autonomy.

4.2.3 Welfare of the population

Individuals are usually the best judges of their own lives and their own life quality. If they see their lives as good, then it is not the legitimate business of others to intervene without explicit permission. Similarly if individuals deem their lives to be worthless other people should not automatically try to keep them alive. But what if public health authorities want to restrict the liberty of individuals in order to promote the welfare of the population at large? The issues of medical prevention from quarantines to prescription drug laws draw their justification from the public good instead of the good of the ones whose freedom is restricted. But how to know when this *public good* or general welfare of the society is genuinely at stake and when certain precautions are based on irrational and moralistic fears that people may have towards each other?

When it comes to social issues like protecting individual patients against the greater interests of the rest of the society, disagreements are likely to emerge. In our heterogeneous liberalist societies, some people believe in torturing potential terrorists while some others do not even believe in quarantining people who carry fatal contagious diseases. In both cases the conflict occurs between individual's rights and the general welfare of the society. In public health, potential measures may range from practices which can be regarded as strictly authoritarian and policies which would be accepted by the most extreme liberals. On one hand, causing anguish and fear among people who relapse in their attempts to lower their slightly high cholesterol level cannot be justified in a liberal framework but, on the other hand, attempts to influence people's behaviour by providing them with truthful information about the connection between lack of calcium, motion and osteoporosis cannot be seen constraining. Individuals simply cannot make autonomous decisions without adequate information. And, in addition to that, they need critical thinking in order to be able to distinguish misleading marketing, propaganda and *normative wisdom* from scientifically justifiable facts.

Unfortunately – and this cannot be emphasised too much - what some medical authorities tend to forget is that knowledge about the health hazards of certain life-styles does not mean that the citizens should act accordingly. Individual citizens usually let their passing wants, life-style values and other possible factors influence their preferences and choices even if they do believe the probabilities served by medical authorities. In other words, anti-liberal medical authorities who prefer prohibitions and restrictions to information campaigns and health education, justifying them with the ineffectiveness of antipaternalistic means, are (in fact either mistaken in their views or) fundamentally insensitive as regards claims to personal autonomy and individual self-determination. Public health authorities may try to say that it is not their aim to distress people and to promote authoritarianism, their sincere aim simply being to promote the physical wellbeing of the population. Most of us are willing to admit that at least certain level of physical health is necessary to our all-over wellbeing but that this admission does not mean that health and wellbeing as seen by medical authorities would be the one and only or even highest goal in a liberal, democratic society. Public authorities should recognize that civil liberty is among the values which ought to be protected by policy makers.

A firm commitment to liberty should imply that the freedom of individuals to smoke, drink, eat saturated fatty foods and avoid exercise annuls the official obligations and entitlements to

interfere with the self-chosen life-styles of the adult population. Someone might want to argue that the only things that can be achieved by unhealthy life-styles are transitory pleasures now, and an increased probability of illness and premature death in the future. Still, in a liberal society the value of people's transitory pleasures cannot be that easily discarded. Since a liberal society is based on the idea of neutrality in conceptions of good, avoidance of health risks and maximisation of physical health does not become a duty just because it happens to maximise the good as seen by the public authorities, however well-informed and rational they may be. In a liberal democracy, individuals should be entitled to make their own decisions, when these decisions concern only or primarily themselves.³⁸ This means that people can quite legitimately make choices which are bad for their own health. The greater knowledge and impartiality of the authorities guarantee their expertise in the epistemic sense, but when it comes to matters which fall within the scope of people's self-determination and autonomy, they are morally on their own.

4.2.4 An example: how can autonomy be respected in health education?

Granted that autonomy is valuable and that it should be respected in health policies what does this mean for health education which is the corner stone of what public health authorities are supposed to do in a liberalist society? Gerald Dworkin has presented the following list of attitudes, norms and preferences which are usually associated with respect for autonomy in policy-making:

1. We have favourable attitudes towards those methods of influence which support the self-respect and dignity of those who are being influenced.
2. Methods of influence which are destructive of the ability to individuals to reflect rationally on their interests should not be used.
3. Methods should not be used which affect in fundamental ways the personal identity of individuals
4. Methods which rely essentially on deception, on keeping the agent in ignorance of relevant facts, are to be avoided.
5. Modes of influence which are not physically intrusive are preferable to those which are.
6. There will be some restrictions on the time in which the changes take place and the ability of the agent to resist the effects of various modes of influence.
7. We prefer methods of influence which work through the cognitive and affective structure of the agent, which require the active participation of the agent in producing the change, to those which short-circuit the desires and beliefs of the agent and make him a passive recipient of the changes.³⁹

Although Dworkin's points are rather general, many of them can be employed almost directly to the assessment and redefinition of health education. The following practical guidelines, which are partly overlapping, are perhaps the most important that can be derived from Dworkin's ideas:

1. Modes of health education that violate the autonomy of individuals should not be encouraged.
2. Self-evidently, health education should not involve punishment.
3. Modes of health-education that enhance the autonomy of individuals ought to be encouraged.
4. Health education should not be frightening or overly emotional, nor should it evoke feelings of guilt or build up undue pressures in the life-styles chosen by individuals.
5. Health education should be ideally to disseminate truthful information about the causes of ill health and the dangers confronting people at home, at the work place and elsewhere.

6. Since lying and deception are to be condemned, public health authorities should not conceal, or omit to inform people about, the good effects of life-styles which are regarded as unhealthy, for instance, the advantages of consuming moderate quantities of alcohol.⁴⁰

If all these norms are taken seriously, health education ceases to be a mechanical means to promote people's physical wellbeing, and becomes an autonomy-enhancing method of health policy. The best way to define this policy is to say that, instead of trying to make people healthy against their own wishes, health education should aim at making people aware of the conditions of their own health. Individuals cannot be legitimately forced into physical wellbeing regardless of their self-determined decisions, but they can, and should, be informed about the factors that are relevant to their health. The availability of the information can eventually lead to the improvement of the physical wellbeing of the population, but if it does, this should be treated as a bonus, not as the primary goal of health education.

In addition to face-to-face clinical paternalism and public health education, the populations of our societies are also subject to more delicate and far more extensive forms of possible intervention. These include laws regulations dangerous behaviour in everyday life, regulations concerning the manufacture, advertising, sale and consumption of drugs and intoxicating substances, and preventive medical and socio-political measures such as quarantines, vaccinations, and plumbing. In fact, a surprisingly large part of these regulations and activities are ethically unproblematic, either because there are good non-paternalistic grounds for upholding and approving them, or because their paternalism is, measured by the standards of freedom and autonomy, clearly legitimate or illegitimate. Quarantines and quarantine-like measures such as home arrest, electronic surveillance, compulsory hospitalization and imprisonment are justifiable, if they are justifiable, by an appeal to the potential harm inflicted on other people by carriers of communicable diseases.

In a liberal, egalitarian society there are many qualifications which reduce the ethical acceptability of isolation policies in real-life situations: the threat posed on others may be symbolic rather than concrete, the isolation can be comparable to imprisonment of a person who has never committed a crime, the identification of the ones to be isolated would sometimes require serious violations of civil liberties, and compulsory hospitalizations lack medical purpose when no actual cure is available. We should not forget either that elements of xenophobia, prejudice, moralism and misleading interpretation of probabilities may seriously endanger civil rights. Once again, the promotion of so-called general good – whatever it happens to be – is not the only ethical consideration when coercive policies are discussed in a liberal framework.

Liberal intuition in social and medical policies may lead to combining need-based positive claim-rights with the antipaternalistic, negative concept of liberty. This implies that individuals should be left free to make their own choices, provided that the consequences of their decisions are not likely to have a negative effect on the basic need-satisfaction of others. In this model there is no assumption of other agents – be it the state, community, cultural leaders, religious teachers, being more knowledgeable than the individual themselves regarding their life-style choices. No one is supposed to possess normative wisdom entitling them to paternalistic behaviour if and when we are talking of ordinary adult citizens. The prevailing premise is that human beings can and should be free even if their actions seem irrational to others. As I said earlier, what distinguishes welfare or egalitarian liberalism or liberal egalitarianism (whatever name we want to use) from libertarianism is that the former take people's needs fully into account in ethical and political decision-making.

Libertarians can happily live among people who suffer from easily curable diseases and injuries but those who have taken to egalitarian ideals, even in their individualistic forms, cannot. In health care policy-making liberal egalitarianism stands for an extensive system of public health care, accompanied with a zealous respect for the autonomy of patients and other users of the services. Democracy in this model means both concern for the well-being of the population and consideration towards the privacy and freedom of individuals. Respect for individuals should not be mistaken for unquestioning respect of group rights and group autonomy. The ideal of toleration and respect for people's values and beliefs does not mean that self-professed leaders can make, in the name of cultural, ethnic or cultural rights demands for special treatments or exemptions in practices merely be reference to the fact that they represent a minority. Taking individual rights seriously is the only way to at least try to guarantee that all citizens are equal members of a democratic – and liberal – society.

4.3 Kant's philosophy and the understanding of public health

Public health is to do good, either to promote health or to prevent disease. Programs of promoting more exercise, avoiding fat, stopping smoking and reducing alcohol intake are all driven by the impetus to do good in society. These programs thus enact prescriptions on how to live lives individually and collectively. The goals and the means to be used are mostly framed in terms of individual and social responsibility: to what extent are individuals expected to take up responsibility for the care of their bodies and lives and to what extent may they be framed, enforced or limited in living their lives? May individuals be forced to be put in quarantine when afflicted by infectious diseases such as tuberculosis or SARS? May individuals be forced to give up risky behaviour such as smoking, eating fat, living a motionless life or performing stressful work? Should citizens contribute to the prosperity and wealth of the community? Should compulsory measures be permissible to ensure greater equity in society, in the sense that all citizens should share the risks and benefits of public measures? The answer to these questions given by the public health community would often be *yes!* The basic question that remains is *to what extent* individuals may be forced, that is, to what extent public health programs may be voluntary or mandatory.

This tension between personal freedom and collective good is framed in terms of individual and social responsibility. Whereas in former times the emphasis was put on personal freedom, in recent years a shift is notable towards the collective good: citizens have a responsibility, obligation or even a duty to contribute through their healthy behaviour to society at large.

In this way the fundamental tenet of public health is by-passed: what is public health anyway? What is the deeper sense of the notion of *public* in striving for public health? Kant's philosophy is relevant here, precisely because it asks fundamental questions about our views on the notion of public, of doing good, and of individual and social responsibility. The basic line of argument in Kant's philosophy is that any attempt to do good is inherently operating power.ⁱ In this respect any public health policy of benevolence is exerting power and control.ⁱⁱ But power has to be legitimized. According to Kant the framing of any public problem cannot be based on doing good *only*. Rather doing good should be framed as doing right and the notion of public should encompass the power position of those, including officers like public health professionals, who claim to do good on behalf of society.

This chapter elaborates on the power and potential of Kant's philosophy for the field of public health in three parts (after the first section which presents an introduction to and exposition of Kant's moral and political philosophy). These three parts deal with three principal ways that the public health community is avoiding the fundamental question: what is public health?

ⁱ In medical ethics and practical philosophy a distinction is made between beneficence and non-maleficence, that is between promoting good and preventing harm. This topic between the 'positive' and the 'negative' side in medicine and health care that is between disease and health is bypassed in this paper. The issue of power and its legitimate basis is fundamental both to preventing harm (or disease) and promoting good (or health).

ⁱⁱ Foucault in fact has taken up this Kantian point, first in addressing in his doctoral thesis Kant's 'Anthropology in pragmatic perspective', then in '*Les Mots et Les Choses*', by arguing that in modern societies power operates not through repression, coercion and direct control, but through experts, science and expert knowledge. Whereas Kant looked for ways such power could be criticized and reflected upon, Foucault took up Kant's point of subtle power in society as if such a power could not be resisted or criticized. Cf. Hemminger A. Kritik und Geschichte Foucault – eine Erbe Kants? Berlin: Philo, 2004.

The first way is to argue that the doing good or the preventing bad is justified because the good or the bad is intrinsically good or bad, whence the promoting of the good or the preventing of the bad is considered to be intrinsically justified. Kant's answer is that this is not enough; the crucial thing is to do just (or to do right).

The second way is to frame public health measures in the oppositional scheme of individual versus social good (and responsibility), say, broadly speaking, the opposition between liberalism and communitarianism. In this way public health issues seem to be necessarily framed as restricting or relaxing freedom of individuals as individuals or as members of groups. Kant transcends this opposition showing that individuality can only be constituted in sociality, but, conversely, that sociality can only be constituted through individuality. Although Kant is considered one of the champions of liberalism – and indeed he is – his position is quite unique, because he holds a relational view on individuals and communities co-constituting each other, particularly focusing on substantive autonomy as a way of inclusion and social participation.

The third way the public health community is avoiding the basic question by framing public health issues in terms of responsibility, that is, that one should *respond* to one's actions to others. This view implies that the consequences of one's deeds are morally relevant by themselves. The person who drinks, eats fat, smokes and lives a stressful life can be held responsible for his or her early death, whether it is due to myocardial infarction, lung cancer or some other medical condition. Kant, however, notes that the effects of one's deed do not carry any *intrinsically* moral load. Two car drivers causing quite similar traffic accidents with quite similar consequences because of a quite similar cause, i.e. some mechanical problem of the brakes, are quite differently judged knowing that the one driver was and the other driver was not neglecting regular check up of his or her car. Most interpreters have argued that Kant is vehemently opposing utilitarianism – and indeed he was as we will see later on – but the ensuing conclusion that Kant is therefore a deontologist does not hold.ⁱⁱⁱ Instead he holds a relational view on the actions and their consequences similar to his views on property and ownership: being the owner of some object, a house, a car or something else, is not a relationship intrinsic to the owner and that object, but is intrinsic to the relationship between persons, the one having certain entitlements and obligations whereas the other person has not.

In exploring these three ways in which the public health community frames public health issues, the problems associated with the very notion of public in the conceptualisation of public health itself is, become evident. Kant is one of the few philosophers (with John Dewey as another good exception), who deeply thought over the problematic nature of the notion of

ⁱⁱⁱ This refers to the 'new' literature on Kantian philosophy, which exposes that Kant's philosophy should be read much more in a pragmatic, 'Aristotelean', and political way. Cf. Herman B. *The Practice of Moral Judgment*. Cambridge, MA: Harvard University Press, 1993; O. O'Neill. *Towards Justice and Virtue*. Cambridge University Press, 1996; Allison HE. *Kant's Theory of Freedom*. Cambridge: Cambridge University Press, 1990 ; Wood A. *Kant's Ethical Thought*, Cambridge: Cambridge University Press, 1996.

References to Kant's political essays in this paper will be to the translations: *Kant's Political Writings*, trans. H.B. Nisbet, ed. by H. Reiss (Cambridge: Cambridge University Press, 2nd enlarged edition, 1991) for "An Answer to the Question: What is Enlightenment?", pp. 54-60; "On the Common Saying: 'This May Be True in Theory, But It Does Not Apply in Practice: II. On the Relationship of Theory to Practice in Political Right", pp. 73-86; "Perpetual Peace: Appendix I On the Disagreement between Morals and Politics in Relation to Perpetual Peace", pp. 116-125; "Perpetual Peace: Appendix II On the Disagreement between Morals and Politics in Relation to the Transcendental Concept of Public Right", pp. 125-130 ; "The Metaphysics of Morals: The Theory of Right, PartII: Public Right", pp. 136-175.

public, again and again. If this is taken into account, then public health may become a sound practice, a practice which not only performs benevolent programs and policies, but which critically reflects upon its own ends and goals and acknowledges its powerful position in modern society.

4.3.1 Kant's moral and political philosophy: an introduction

Kant is considered as the most significant Western philosopher since Aristotle and the Greek tradition in philosophy ranging from Plato, Socrates and Epicurus. Kant is believed to be the founding father of the concept of autonomy, both in the European and the Anglo-American context. Beauchamp and Childress explain that respect for autonomy flows from Kant's recognition that "*all persons have unconditional worth, each having the capacity to determine his or her own destiny. To violate a person's autonomy is to treat that person merely as a means, that is, in accordance with other's goals without regard to that person's own goals*".⁴¹ Indeed, Kant has inspired and still inspires many debates in health care and public health, perhaps also because of his views on duties, obligations and responsibility, concepts which are so prone in debates on freedom and communality in health care, public health and in society at large; some authors inspired by Kant will reappear in this chapter.

Kant's philosophy has been interpreted in terms of autonomy, self-determination, integrity and privacy amidst the other thinkers of liberalism such as John Stuart Mill and John Locke. This interpretation is a very narrow conception of the philosophy of Kant. Such a narrow conception fits the instrumentalization and rationalization in contemporary society and medicine, but is not adequate. The central problem Kant was working on was on bridging the moral choices of the individual and the community, the secular and faith based systems of right and good, and the persons in power in society – including professionals in health care and public health – and the citizens in the community at large.

The following case presented by Bernard Williams in his moral luck debate with Thomas Nagel, and further discussed by Donna Dickenson⁴² might help to introduce Kant's philosophy:

A traveller into a South American market square, Jim, meets Captain Pedro who is about to execute twenty Indians. Pedro offers Jim a chance to save all the Indians but one, whom Jim must kill with his own hand. If Jim refuses, Pedro says that all the executions will proceed; if he assents, Pedro promises that the other nineteen Indians will go free.

Interestingly, Williams concludes, rather grudgingly, that the utilitarian prescription – that Jim should kill the Indian – is right in this case, but not for the conventional utilitarian reasons. Those who want a more contemporary example may choose the example of the policeman and the terrorist and ask whether it is allowed to torture the terrorist in order to find out information about a bomb which certainly will take the lives of many innocent citizens. In any case, a Kantian *could* and *would* argue, as many interpreters of Kant's philosophy have concluded, that Jim should not shoot one of the Indians to save the others.^{iv}

^{iv} Kant discusses these issues in his essay: "*On a Supposed Right to Tell Lies from Benevolent Motives*". (see in: Abbott T.K. (trans.) *Kant's Critique of Practical Reason and Other Works on the Theory of Ethics*. London: Longmans, Green and Co.). In this essay Kant asks whether you should tell the truth to someone who comes to your door asking if someone who he says that he wants to murder is inside. Yes, says Kant, and up to now many philosophers, sympathetic to Kant's philosophy, are struggling with this case, with the intent of '*trying to rescue Kant from himself*'. Cf. Proceedings of the Kantian Society 2007 (forthcoming).

How should ethics deal with such a case? Kant gives two answers. His first answer is the categorical imperative expressed as follows: “*An action is morally right for a person in a certain situation if and only if, the person’s reason for carrying out the action is a reason that he or she would be willing to have every person act on, in any similar situation.*”

In this respect, two criteria are at stake:

1. The person’s reasons for acting must be reasons that others can act upon, at least in principle (a principle has to be *universal*);
2. The person’s reasons for acting must be the reason he or she would be willing to accept when applied to his or her self (a principle has to be *reciprocal*).

The fundamental tenet of Kant’s philosophy focuses on the *interior features* and not on the consequences of an individual’s external actions. Moral right and wrong do have to be distinguished according to Kant not by what a person accomplishes as such, but by the reasons a person gives for what he tries to do. We can easily understand from the case above what Kant had in mind: the outcome of Jim’s action – either accepting or refuting the offer of Captain Pedro – is not less *good* (if considered as *good*) or not less *wrong* (if considered as *wrong*), if Captain Pedro would shoot the Indians whatever way Jim decided.^v

The second answer Kant gives is his tenet for “*treating humanity as an end*”, which can be expressed in the following principle: “*An action is morally right for a person if, and only if, in performing the action, the person does not use others merely as a means for advancing his or her own interest, but also both respects and develops their capacity to choose freely for themselves.*”

Two criteria are involved here as well:

1. Respecting each person’s freedom by treating others only as they have freely consented to be treated beforehand;
2. Developing each person’s capacity to freely choose for him or herself the aims he or she will pursue.

Thus, we might discuss the case of Jim and Pedro in terms of whether Jim’s freedom was respected. No, Kant would say, not because Jim had no choice – he was given a choice – , but because Pedro’s offer included no moral choice set on Kant’s terms.^{vi}

The crucial thing Kant is saying is that it is not good outcome but the intrinsic features of the action themselves which determine whether actions are morally right or wrong: a personal

^v This has been debated in philosophy under the label of the ‘moral luck’ banner, which is only one of the aspects Kant worried about, he was much more interested in the ‘other side of the medal’, namely in those cases where the outcomes were good, but not due to external contingencies, but due to ‘internal’ dispositions, being a crook, a Samaritan, or whatever, but NOT following the duty of the moral law: the paradigmatic case here is all those in power who always claim that a certain policy is the right thing to do in terms of what is ‘good’ to do (and not ‘right’ or ‘just’).

^{vi} The issue, as discussed by Dickenson (see *Moral Luck in Medical Ethics and Practical Politics*. Hants: Gower Publishing Company Ltd, 1991, p. 5), is that Kant is concerned with the question that there is a “quintessential form of value, moral value, which is ‘unconditioned’, that is free from external contingency; but other contingencies have to be considered, such as ‘constitutive luck’, that is, good fortune in having the ‘right’ or the most praiseworthy inclinations, abilities, or temperament (p. 5) – say Jim had the moral luck for doing the good thing because he was lucky enough for his character. Again, this passes the point Kant was trying to capture, i.e. to do good by doing right or just (in particular for those who are in power).

promise, a debt to another person, a relational feeling such as in a parent-child, brother-sister, or friendship relation or the fairness of distribution do carry their own intrinsic features. Friendship includes that one should not give up one friend in order to gain two other friends. Pedro's action to shoot one Indian in order to rescue the others is not better or worse considering his *state of mind*, being a Samaritan (because of its nature of character or his Spartan education to fear nothing or his religious belief to do only good things). Kant vehemently opposes the other *grand* tradition in ethics, namely the consequential or utilitarian ethics, which says that the right action for a particular occasion is the one that produces greater utility than any other possible action. In the case described above the best action to do then is not that which produces the most utility for the person performing the action nor that action which produces the most utility for all persons affected by the action, including the person performing the action. That Kant opposes utilitarian philosophy is important for two reasons: one is that Kant is particularly focusing on the problem how an individual's and community's moral life can be enriched intrinsically; the other that Kant builds his philosophy on the Aristotelian *virtue* ethics: Kant's work is much more on moral character instead of rigid duties and obligations as many have interpreted Kant.

Kant's central notion therefore is not autonomy as such, but human dignity, reason and responsibility. Kantian ethics directs the individual to associate with and speak out in the community, thus not focusing on a liberal, atomistic view of individuals, but on a social self that lives in and through the community. Reversely, Kant was very much interested in how communities could enrich themselves. The paradigmatic case here is the bonding of parents and children in order to let the children leave those social bonds and find their own yet new social bonds.

Most philosophers have interpreted Kant's philosophy as a universalistic, deontological ethics. However, Kant's philosophy is not strictly deontological as many have interpreted. Kant's search for ethical principles is not a search for (universal) features of human beings. Rather is it a search for how ethical systems have to be constructed. It is not the *state of mind* of Pedro which decides on the *goodness* of his actions (whatever way he would have decided: either to reject or to accept Pedro's proposal). So it is not the *internal disposition* of the ethical agent *per se* which counts, it is the practice and the ethical fabric of this practice which is decisive. One way to clarify this is to look at the example of the police officer shouting at a skating girl: "*The ice over there is weak*".^{vii} Who wants to understand what the police officer is doing here has to focus on what the police officer is doing, namely warning! Crucial to the acting of the police officer are not intentions – the officer might be in a good mood, the skating girl is her daughter or the officer is driven by philanthropy, sense of duty, or stickling for regulations and discipline. Perhaps there were no intentions at all. Instead, the kernel here is the practice of warning: its style, conventions, rules, etc. The warning itself is considered by Kant as an action with moral worth, neither because the police officer has good intentions nor because the warning produces the wished for result by saving the girl. Whatever result and whatever accompanying dispositions of the officer in warning the skating girl, WARNING (in such circumstances) is by itself an ethically sound practice.

Kant's philosophy is indeed universalistic in the sense that his *universal principle of right*, in conformity with his categorical imperative, says: "*Any action is right if it can coexist with*

^{vii} See for such a very apt analysis of 'rules' and 'rationalities' of practices: De Vries G. Zeppelins – Over filosofie, technologie en cultuur [Zeppelins – About Philosophy, Technology, and Culture]. Amsterdam: Van Genneep 1999, p. 132.

everyone's freedom in accordance with a universal law, or if on its maxim the freedom of choice of each can coexist with everyone's freedom in accordance with a universal law."

But mostly, it is neglected that the second and most important aspect of this universalism, is in fact the *reciprocal* feature of the categorical imperative. If I am willing to claim that people should not eat fat because they show risky health behaviour, other people might ask for reasons why I show my own sort of risky behaviour, say being very ambitious and leading a stressful life. If someone argues that he or she does not want to live in a kind of world with people showing risky behaviour, other people can argue why they should live in a risk-averting world. Rights (and norms) are in Kant's view relational affairs, but not only negatively. Property rights are relations between people, not only in the sense that other people are forbidden to trespass my home or that my home remains mine still when I am not at home, but they are also productive in social behaviour: I can invite people at my home, I can show hospitality, I can ask other people for having meetings to associate, and so on. Yet, most of our rights (and ethical norms), so Kant claims, are not strict and conclusive, but are mostly provisional. Kant is here quite modest, since he is dealing with the fundamental question *who shall be judge of political right?* In the absence of perfect divine judgment and of reliable judgment on the part of rulers, politicians, and public officials, Kant identifies the public sphere as the most important place to approximate perfect judgment on matters of right.

Thus, Kant is not a *top-down* but a *bottom-up* ethicist. His maxims or rules of conduct are Wittgensteinian sort of rules "*containing as much of the particulars of person and circumstance as the agent judges are necessary to describe and account for his proposed action*".⁴³ Kant's ethical agents are not naïve; they are embedded in life forms and practices. The man on the boat saving his wife knows that saving *his* wife matters to him, but saving her on a Tuesday is not relevant (but might be later on as a celebration day). This is the big difference with Rawls and Habermas. Saving as a practice has its own ethical fabric and is therefore not unconditional, e.g. by saving someone while throwing someone else overboard. In this way Kant's moral philosophy is connected to his political philosophy. Any practice cannot be justified in terms of doing good (or preventing bad) only. The principles making up the ethical fabric of that practice have to be the right principles. Right in the sense that practices encourage citizen autonomy along with civil rights, rights of participation and the social basis of the use of these rights.

4.3.2 The first way: Doing good and the problem of instrumental rationality

There are many challenges to the public health. Obesity is a world-wide problem; pollution causes many thousands of deaths; HIV spreads over the world; infectious diseases, once conceived of as being eradicated, threaten modern societies; burnout and stress endanger wealth and prosperity and the young and women increasingly drink and smoke. In the early 1980s, carefully controlled, scientifically designed health promotion interventions – such as the many heart disease prevention programs (the Stanford three- and five-community studies, the Minnesota Heart Health plan, the Pawtucket trials, the Karelia intervention, the highly intensive and individualized Multiple Risk Factor Intervention Trials (MRFIT) – did not produce much success. Thus, the public health community urgently felt the need for some *wins* in *improving* the public health approach. One of the main thrusts to achieve this was via reduction in tobacco consumption. The evidence on the morbidity and mortality associated with smoking is clear (although still disputed by some in the tobacco lobby). By presenting

this evidence to the public and use of various incentives and restrictive measures, public health professionals have succeeded in reducing smoking prevalence from 70% in the 1950s to 30%. As a consequence harm from smoking related disease is prevented.

The pessimistic view on public health is exposed by critical thinkers such as Buchanan⁴⁴. The optimistic view is held by communitarian thinkers such as Beauchamps. Both views can be found in the public health community, although the science driven health promotion paradigm dominates. This unstable opposition between the pessimistic and the optimistic view on public health will not be resolved in this chapter. On the contrary, we have to delve deeper, because this analysis will show that a common theme underlies both sides. A good start is to analyze one critical thinker, namely Buchanan.⁴⁴

The major line of argument against current public health practice Buchanan derives from the philosopher Charles Taylor – particularly his analysis *The Malaise of Modernity* (1992) – which traces two important principles, on the one hand *the dark side of individualism* and on the other hand *the primacy of instrumental reason*. The latter is especially picked up by Buchanan. Instrumental reason is the separation of ends and means, hence determining the best available means for the ends set by public health. As defined by Taylor: “By ‘instrumental reason’, I mean the kind of rationality we draw on when we calculate the most economical applications of means to a given end. Maximum efficiency, the best cost-output ratio, is its measure of success” (p10). Indeed, many of the ends set by the public health seem to be fixed and indisputable: stop smoking, avoid fat, exercise more, eat healthy food, etc. The only remaining issue then is what the best and most effective means are. On this basis Buchanan criticizes the public health community: “the quest for a science of health promotion both reproduces and reinforces the instrumental outlook that Taylor and others see at the core of our modern moral malaise” (p11). Indeed, relevant passages can be extracted from the public health field to sustain this claim: “research programs have been established to identify and test the most effective methods for achieving individual behavioral change” “randomized control trials are the most rigorous tests of health behavior interventions”, and “the search for truth and for an ultimate understanding of the forces that make humans think, feel, and act as they do is the long-term goal”⁴⁵. In these and other cases there is no discussion on the ends themselves. The criticism Buchanan⁴⁴ exposes is to focus again on the values underlying the process of setting the ends: well-being, virtues, autonomy, solidarity, etc. We do see here how Buchanan departs from Kant’s philosophy stating that in scrutinizing public health ends, as Buchanan says quoting from Kant’s philosophy: “Act so that you treat humanity, whether in your own person or that of another, always as an end and never as a means only”.

Kant’s categorical imperative indeed forms an important yardstick for evaluating the ends set by the public health community. However, Buchanan’s⁴⁴ main argument here is that if, and only if, the ends have been set reasonably, through some sort of deliberative process, then the rest follows. Thus, as Buchanan says, “It does make a difference, for example, whether young people consciously and deliberately choose not to use drugs, or whether their attitudes are effectively altered through ‘indirect influence techniques’ and ‘conditioning in low thought situations’.” Likewise, people may lose weight by taking pills, but they will not gain the dignity and self-respect that comes through exercising self-control. Buchanan⁴⁴ quotes the sociologist Robert Bellah at length who spells out the implications for health promotion: “The purpose ... is not to produce or control anything but to discover through mutual discussion and reflection between free citizens the most appropriate ways, under present conditions, of living the ethically good life ... It is precisely the point about praxis [social practice] that it

has no extraneous product. It has an end, namely, the good of human beings, but that end is attained through itself, that is, through action or practice that is ethical and political For 'helping professionals', this would involve toleration of high levels of uncertainty in trying to aid people to improve their own skills of practical autonomy, rather than categorizing them in terms of preconceived theories with resulting automatic formulas for treatment.(p19)"

In line with Bellah's reasoning Buchanan⁴⁴ asks for modesty on behalf of public health professionals and rightly so. *High levels of uncertainty* should be the credo as well as the aim to interact and deliberate over the ends to be set. This has a strong Habermas' kind of ring, which indeed can be extracted from Kant's philosophy as Habermas did. But Kant is quite sceptical about this approach of social deliberation as it stands alone. The reason is that any practice which aims at doing good has a drive of domination and control. As Dahrendorf writes, "*it is difficult to think of human association without an element of domination. Where there is society, there is power*".^{viii}

This approach set by Buchanan⁴⁴ and others is deeply flawed. It avoids the fundamental problem. The public health community feels intrinsically responsible for promoting public health and rightly so. If smoking leads to morbidity, and particularly in *innocent* people, e.g. children, pregnant women, asthmatic people etc., then certainly one would like to develop programmes and policies to promote the good and to prevent the bad. If providing healthy food programs in schools and at work improve health, one would surely enact such programs. "*Nevertheless, ... the inherent exercise of power [in developing techniques to effect behavior change] remains a problem*".^{ix} The key tenet here is that both sides identify the problem of domination, power and control at the same level, namely at the level of the relationship between ends and means. Buchanan and other critics of the public health endeavour to solve the problem by improving the setting of the ends. Thus, Buchanan refers to Selznick^x: "*The claims of efficiency are strong, but they cannot justify practices that reduce human beings to 'means only'. Such practices make them victims of domination*". Domination is the key term here, indeed, but cannot be rescued in terms of social deliberation for setting the ends alone, since it still aims at benevolence alone. The proponents of the public health paradigm hope to solve the problem through relaxing the methods, that is by flexibly moving between the offerings of methods on a voluntary or a mandatory basis, but again lacks the legitimate basis by denying justice. Both approaches will not do as Kant's philosophy exposes. For, public health intrinsically engages in a practice of doing good, that is, to aim at making people do

^{viii} Marshall TH, Bottomore T. *Citizenship and Social Class*, London: Pluto Classic Press, 1992, p. 26. In the public health literature this is also known as the 'democracy problem', that is should experts of the public set the ends of public health policies (cf. Murray CJL, Salomon JA, Mathers CD and Lopez AD, eds. *Summary measures of population health – concepts, ethics, measurement and applications*. WHO Geneva 2002, particularly part 12 and 14.)

^{ix} quoted from Buchanan, p. 15 c.f. Nordenfelt L. Towards a new paradigm for health promotion. *Medicine, Health Care and Philosophy* 2000; 3:317-319, who makes the argument that Buchanan does not criticize the biological kind of public health, say for instance environmental policy or biomedical prevention. The problem is however deeper, because it affects both sides, e.g. enacting laws for banning smoking relates both to behaviour of people and 'biological effects', i.e. the reduction of lung cancer caused by passive smoking. It is about the question of making to do people what one wants them to do through more or less persuasive or even compulsive measures (referring to Nordenfelt p.319).

^x Buchanan claims that Selznick 'brings home the Kantian point'. In fact, he doesn't as is argued in this paper: the setting of the 'ends' should be captured within the framework of Kant's political philosophy, which claims that the setting of the ends cannot be based (in any politics or policy) on the notion of benevolence alone, but has to be framed within the notion of the just or the right.

what one wants them to do through more or less persuasive or even compulsive measures.^{xi} Kant offers here a painstaking analysis in stating that enacting policies to do good can never be based on benevolence itself, as utilitarianism, communitarianism, or (egalitarian) liberalism would have it.^{xii}

Admittedly, many public health programmes and policies do not aim at promoting *good behaviour* only, proposing health and related conditions in terms of equity and fairness, say by promoting equal opportunities and defining health as a resource for social participation. If so, then such programs and policies cannot frame the issue in terms of benevolence. The benevolent policy should also be a just policy, a policy that performs the *right* thing.

In this sense the passive smoking case is such an intriguing case. For, few public health officials seem to acknowledge that the end of reducing passive smoking should be disputed – this is the point of Buchanan⁴⁴ – whence compulsive measures are ethically justified because the harm to be prevented is so huge. Even raising questions with regard to this strict banning policy provokes disbelief and disdain amongst public health professionals.

Here is the problem: where is the injustice which should be repaired and compensated for or which should be prevented? Those who think that this is a silly question, might get the boomerang back. For, anyone who defies this question, claims that doing good is by itself the legitimate ground for enacting public policies. Yet, this would implicate that all kinds of behaviour considered *deviant* by the majority of the population – ranging from homosexuality to nasty fat people to eccentric artists – can be banned under the label of doing good to society. Reversely, this implies that all kinds of behaviour considered *virtuous* by the majority of the population can be the legitimate ground of public policies.

This leads to the moralizing of politics, whether this is inspired, in the words of Taylor, by the dark side of individualism or the bright side of communality. This leads to a political philosophy which starts from the distinction between the individual and the social, instead of the distinction between the private and the public, which plays a crucial role in Kant's political philosophy and which has been taken up by Dewey more than a century later.

4.3.3 The second way: individual and social responsibility

Public health programs enact prescriptions on how to live lives individually and collectively. The goals and the means to be used are mostly framed in terms of individual and social responsibility, whence the tension between personal freedom and collective good arises.

The basic point Kant makes is that the fundamental opposition is not individual – social, but public – private. Here is how Dewey formulates the problem: “*Just as behavior is not anti-social or non-social because privately undertaken, it is not necessarily socially valuable*

^{xi} cf. Nordenfelt L. Towards a new paradigm for health promotion. *Medicine, Health Care and Philosophy* 2000

^{xii} We should distinguish between the moral and political aspect of the problem of doing good. Much of what Kant argues regarding moral behaviour is related to the interactions between moral agents. But the power of Kant's analysis lies in his political philosophy, that is, the way rulers and civic officials – which the ‘helping professionals’ of public health are – exert control and domination. The policies of rulers and officials cannot be based on benevolence alone. Utilist reasoning says something like to do good is to produce the most happiness, communitarianist reasoning that which produces most to the community, and liberals which produces the most freedom (either in a strict individualistic or egalitarian way, the latter if it takes the distributing effects of freedom into account probably comes most close to Kant).

*because carried on in the name of the public by public agents. (...) We distinguish private and public buildings, private and public schools, private paths and public highways, private assets and public funds, private persons and public officials. It is our thesis that in this distinction we find the key to the nature and office of the state. It is not without significance that etymologically 'private' is defined in opposition to 'official', a private person being one deprived of public position."*⁴⁶

It is precisely this notion of public official which plays such a crucial role in Kant's political philosophy in which he talks about public and private reason (a topic also picked up by Hannah Arendt). A private use of reason is, Kant says, "*that which a person may make of it in a particular civil post or office which is entrusted to him*".⁴⁷ In such a case the audience to which the office holder addresses himself is *restricted*. Then, Kant says while pleading for the public use of reason: "*But I hear from all sides the cry: don't argue! The officer says: 'Don't argue, but rather march!' The tax collector says: 'Don't argue, but rather pay!' The clergyman says: 'Don't argue, but rather believe!' (...) Here freedom is restricted everywhere*".⁴⁷ Kant's use of the notion of private reason is therefore specific. What he has in mind, is not that private reasoning is merely personal or individual, but is restricted to the *civil* post or office.

The gist of Kant's thinking is that public officers are facing a double task. They are, as an officer holder, bound to the regulations, instructions and conventions of their office. In these cases their position is defined by the authority of their office, whence their audience is *restricted* and their use of reason merely *private*. In these circumstances public officers communicate with each other but on Kant's view much of that communication presupposes some authority, say the policy, style or culture of some ministry department, committee or organization. Only, if an officer rejects such authority and "*as a scholar addressing the real public (i.e. the world at large) ... speaks in his own person*",⁴⁷ a public use of reason takes place.

Kant used the dichotomy public and private upside down. The word *public* denoted in German political and juridical circles the domain of public affairs reigned by the *prince*. Kant turned the meaning of the term *public* around, and used it to break up the power of the state and its executive organs. Yet the countervailing power is not the public *out there*, the public in Kant's view is a space where the regulators and executors can throw off the yoke of power and authority. Kant was talking about the liberating forces in the regions of power, not in the wider audience itself.^{xiii} Kant is trying to liberate forces within the offices of power themselves, claiming that this yielded reflective understanding to the centre of power. Freedom benefits the sovereign; otherwise the sovereign would be deprived, as Kant wrote in 1793, "*of any knowledge of matters which he himself would change if only he knew them. Hence, to limit this freedom would bring him into contraction with himself*".^{xiv} Kant is here not acting in the *deliberative mood*; instead he is working in the *reflective mood*.^{xv}

^{xiii} Kant was much more sceptical about the power of this wider audience than Habermas and Rawls later on presumed.

^{xiv} Laursen, p. 258. JC. The Subversive Kant: The Vocabulary of 'Public' and 'Publicity'. In: Schmidt J., ed. What is enlightenment? Eighteenth-Century answers and Twentieth-Century questions. Berkely: University of California Press 1996; (chapter 9), pp. 253-269. Here and elsewhere Laursen claims that Kant implicitly exposes a subversive political view. This might be so in authoritarian Prussian society, but Kant touches a 'deeper' problem: the reflective nature of power and the union of power with morality.

^{xv} Habermas did misinterpret the 'communicative' (or in his terms the deliberative) part of Kant's philosophy, since the communication is meant to 'reflect' on the authority of the restricted audience.

In this sense Kant opposes the dominant tradition in political philosophy – from classical to contemporary views – which directs our thinking to the *subjects* of power, but not with those who *exercise* the power that impedes or promotes justice. This relates to politics with its dramatic and heroic ring – we know Watergate, we know September 11th, we know Iraq; this also relates to the daily routine of political power with its marginal and incremental effects on the lives of citizens, multiplying the matters of justice and injustice.^{xvi}

Kant is therefore using the terms public and private different as contemporary strands of politics and political theory, such as liberalism, usually frame it. The latter pose government versus citizen, coerciveness versus individual liberty, and public versus private. From such oppositional perspective all sorts of infringements on the citizen, on individual liberty, or on the private sphere, if allowable at all, require scepticism, are in need of legitimisation, and ask for public consent. This important strand of thinking is present in Kant's work as well. After all, as Reiss notes, Kant was a champion of liberalism.⁴⁸ However, there is a second strand of thinking in Kant's work. Kant is putting emphasis here on the morality of political power. Hence, he focuses on the use of (private and public) reason by rulers, politicians, administrators and other public professionals. They should become self-determined, judgmental and responsive officials and should be reflective on their own governing practice.⁴⁹ In this sense, there is a need to enact learning processes and to develop institutional mechanisms to provoke voice within the power circles of social, economic and political life.⁵⁰

The tenet of Kant's political philosophy is therefore: rulers and public officials always argue for the justness of their policies in terms of benevolence. Even in the case of war, it is argued by the rulers in power that wars are in general not doing the good thing, but this one war is just because it produces the good thing: the security, the wealth and prosperity of the country, or whatsoever. This pertains not only to international politics or national politics, but the more so to all those *public officials* who operate the administration, the economy and the civil society. Although public health scientists and professionals tend to see themselves distanced from politics and administration, as being at the service of the public, in Kant's view they are in power, whence eager to justify their policies and methods in terms of benevolence. Autonomy and freedom are therefore not features of individuals and communities *per se*, but characteristics of an institutional practice in which public policies are criticized and reflected upon in terms of just and unjust and right or wrong. Individuals and communities co-constitute each other *through* autonomy and freedom.

4.3.4 The third way: the framing of the public problem as *responsibility*

The public health field frames the notion of public in terms of responsibility for the consequences of behaviour. Smoking is bad behaviour because it hurts many people. Eating fat or exercising too little is bad because it weakens health and fitness, hence disturbing prosperity and wealth of the community. Kant considers this way of reasoning as a dead end. Why is this so? The point Kant is making is that the goodness or badness in the consequences of human actions can never be the sole ground for approving or disapproving or enforcing behaviour. It is not the consequences themselves but the way people relate to each other

^{xvi} Cf for this intriguing view Thompson D.F., *Political Ethics and Public Office*. Harvard University Press, 1987; esp. p. 7. This does not exclude that Kant in other places does use the notion of 'subject' in the ordinary sense that the citizen is 'subjected' to the head of the state or the ruler. Cf. On the Relationship of Theory to Practice in Political Right, p. 84 and p. 85.

through these consequences which is crucial. Why is it ethically justifiable to – or at least ethically reasonable to ask the question whether one should – put a person afflicted with a highly infectious disease in quarantine? Not because of the consequence itself, but because the way we relate to each other through the consequences of our acts: spreading infections to other people can't be the ethical fabric of a sound practice. Otherwise one cannot make a difference, as Tomas Nagel does, between the person who knows and one who does not know they are infected with HIV, while both are infecting someone else with HIV after sexual intercourse, which in reality did occur. The person who does know they are infected with HIV, hereby knowing that he or she might through his or her actions willingly hurt other people, does injustice. Yet, two persons, one infected with HIV and the other one not, both knowing this and agreeing on sexual intercourse, although highly undesirable and probably disapproved by many in society, would not be unjust by itself (in Kant's moral philosophy, that is his philosophy regulating behavioural practices between free and autonomous persons, this could be considered actually impermissible). Both cases undoubtedly lead to a different ethical judgment. Here Kant comes close to Mill's argument that freedom can be infringed when causing harm to others through operating his or her freely chosen actions. Yet, there is an important difference. Even if the other person ends up being inflicted with HIV, this would not count as being unjust *per se*. Harm has been done, but no injustice – which is something else than the problem of *significant harm*. This is the major difference between Mill and Kant. Doing harm is one thing, doing unjust harm is another thing.

Italian law penalizes persons smoking in the presence of a pregnant woman or a breast-feeding woman – no substantive harm is directly suffered by this particular woman (or child) from the exposure to smoke from one cigarette. One could argue that this is a relatively trivial case. The harder case is whether – on the collective level – one is ethically justified to force people such as in the case above to avoid having intercourse (or, more preferably for many perhaps, to force to have only *safe sex*, e.g. because of costs for society, the suffering of the families of the two persons, or whatever). Similarly, passive smoking can be conceived of as unjust because of the costs for society, in which case, the Italian law mentioned above, is just because it symbolizes and expresses the collective concern. Indeed, this would be the line to follow in what Kant argues. But again, any proposal in this direction cannot be based on benevolence only. It has to be just.

Why is Kant so eager to preserve this distinction between doing good and doing right, between consequences of human actions and (un)just consequences? Four reasons come to the fore, the first political, the second epistemological, the third conceptual, and the fourth ethical.

The first reason is the formulation of a problem as a public problem. Dewey takes here the Kantian point: the distinction between the social and the individual is no reliable yardstick for any public policy, for as Dewey says "*The public cannot be identified with the socially useful*" (p.13). So the notion *to do good* cannot be the defining and justifying ground of the public. The public has to be defined differently, namely in terms of "*the indirect consequences of transactions to such an extent that it is deemed necessary to have those consequences systematically cared for*", that is consequences which are considered as unjust, say companies which dump chemicals in farmers' grounds, fast food companies who erect shops close to schools, etc. Why are they unjust? Because consequences are of two kinds, those which affect the persons directly engaged in a transaction, and those which affect others beyond those immediately concerned. In this distinction we find the germ of the distinction between the private and the public. The former is related to the domain of ethics: moral and immoral behaviour to be regulated, the latter to the domain of politics (where the moral judge in most

cases according to Kant should be the public sphere with the vitality of associating and respecting freedom).

Thus, Kant attempts to keep the bonds between the subject as the *author* of the action and the action (with its consequences) as its object. Yet, simultaneously, he tries to keep the judging in terms of just and unjust, since this is the basis for “*systematically cared for*”. In contemporary philosophy of risk this is seen as the outstanding challenge: either to shift away from the notion of authorship and extending the sphere of risks so extensively with the perverse effect that then “*the more pressing and urgent is the search for someone responsible, that is, someone whether a physical or legal person, capable of indemnifying and making reparation. It is as though the multiplication of instances of victimization gives rise to a proportional increase in what we might well call a social resurgence of accusation. The paradox is immense: in a society that speaks of solidarity, out of a deliberate concern to reinforce a philosophy of risk, the vindictive search for whoever is responsible becomes equivalent to a reintroduction of the culpability of those identified as the authors of any harm done*”.⁵¹

The second reason is that Kant doubts that all the consequences can be known.⁵² Only those consequences that arise in the direct transactions between persons can be known. Kant is discussing the *scope* of responsibility: how far in space and time does the responsibility for our acts extend? This scope is unlimited on his view for “*the chain of empirical effects of our acts is virtually endless*” (ibid p.30). Kant’s rationalism has been considered by many (e.g. Nussbaum) been as opposed to *emotionalism*, say, the role of emotions, character and social circumstances. In fact, Kant took the opposition to the utilitarian view on action, since the objective evaluation of harm tends to obliterate the evaluation of the subjective link between an action and its author, thus putting the moral value of security at top level instead of justness (that is of solidarity: we feel at face value that unjust consequences should be cared for and retributed). Kant reflects here on the tradition in Christianity and philosophy: responsible is to account for, that is, can be *imputed* to someone (an individual or a community) which comes from the Latin word *putare*, which actually implies the notion of calculation (in Latin: *comput*), suggesting the idea of a kind of moral bookkeeping of merits and demerits, thus of receipts and expenses, credits and debits, with an eye to a sort of positive or negative balance (p. 14). This relates to the Christian idea of the *great book of debts: the book of life and death*. Only a super being, a divine being, can master such a book. Kant’s idea is that as rational beings gifted with the capacity of giving *reasons for acting* and exerting *agency*, we *sense* the justice and injustice of actions on the face of it. However, the calculation of all the consequences of our acts, individually or collectively, is impossible as is the calculation of all the (unintended) consequences of our interventions to prevent unjust consequences. We see, feel, sense and judge (in)justice of our actions directly, but we can’t see, feel, sense, and judge all the consequences of our actions.

The third, conceptual reason is that Kant rejects moral value as a *preference set*, or as *moral choice set*. Versus *choosing*, he sets his notion of *willing*.⁵³ The basic idea here is that Kant says that in many situations of individual and collective lives where we *value* affairs, our *valuation* is not the scanning of a delimited range of acceptable moral options and then picking out the most attractive member in the set. Besides the problem of settling the difficult question how to choose the moral choice set anyway, Kant here opposes the *restaurant menu* paradigmatic case (although he admits that in many areas of our lives, we can follow this line: discuss things in terms of a choice set, preferences, selection and opportunity costs). But for most of the situations in which our (moral) valuations are at stake, we really follow a radically

different structure of reasoning which does not fit into these categories. If we would relate with a partner or marry someone, we do not line up people to choose or select the one we would like to have as our partner. Similarly this is the case with acting as a parent, a friend, a colleague, a professional, or whatsoever. As Dan-Cohen notes, “*When we are in the grip of moral truth, we are moved by its intrinsic value, rather than by its comparative advantage over other acceptable alternatives*” (p. 130). Giving up one friend to gain two or more other friends is not included in the meaning of friendship. Now certainly in Kant’s philosophy a difficult metaphysical picture is underlying his philosophy: “*the moral law is no more an option for the will than resisting gravity is an option for an apple*” (p. 136), but any person can sense the inevitability of the moral position: being a parent is to care for your children whatever costs this takes, for your self or for others; to defend your country, implies to take care for society and dear ones at the cost of your self, etc. Why can we then on Kant’s view take collective measures to *systematically care for* the consequences of female incision, the silent raping and violence at home – say the missing 40 million women in our world statistics as put forward by Amartya Sen –, or the repair of the *loss of life years* and *loss of QALY’s* in lower social-economic groups? Not because of the consequences themselves, but because in our moral values of *home, partnership, friendship, parenthood*, but also *neighbours* and *fellow citizens*, lie intrinsic value structures which defy the actions stated before. It is not because of the consequences per se, but because these consequences can and should be considered as unjust and therefore as to be taken systematically cared for. Not the harm, but the injustice, that is, the infringing of the inner structure of these values, is at stake.

Similarly, public health measures do have to take up *health* as an intrinsic value, not as an outcome or as a consequence of the myriad of micro-decisions of individuals and communities, but as a personal and social condition of vitality, creativity and sociality. In such cases we repair and should repair unjust inequalities in terms of opportunities, social capacities and environmental conditions.

In short, a conception of autonomy and freedom that consists of options and the agent’s choosing among them is quite at odds with Kant’s description of the moral experience and his conception of the freedom of persons and communities.

The fourth, ethical reason is Kant’s notion that responsibility is the constitution of individual and collective selves and identities.⁵⁴ Choosing is a poor model for how personal and community life is constituted. The one view is the separatist conception: *I* could have gone to law school, to medical school, to philosophy school; *I* could have lived a life with smoking or non-smoking, drinking or not-drinking, eating meat or not eating meat, being ambitious or not, living a stressful live or not, having children or not. The assumption is that *I* or *You* or *We* understand our autonomy as a matter of choosing important aspects of our lives from a variety of options and opportunities. This is the typical utilitarian (or Anglo-American) viewpoint. On this view the identity of either individuals or communities is considered to be fixed (antecedently to or independently of the person’s or group’s life). One can just choose one or the other option!

The other constitutive view holds that a self, either of an individual or a group, is constituted or shaped by its life, that is, the identity is inseparable from the person’s or group’s life.

This is a difficult terrain in philosophy of identity and responsibility. But the point Kant is making here is that responsibility constitutes selves and communities in a reciprocal way. We may explain this by the reciprocal way of how being responsible implies both taking subject

and object responsibility.^{xvii} If *I* am causing an accident by *my* negligent driving, *I* can take up object responsibility (causing the accident), but also taking up subject responsibility (admitting that it is due to *my* negligent driving). If *my* child breaks the window of *my* neighbour, playing hockey or soccer, then *I* can take up object-responsibility (accusing *my* self and paying up for the broken window), hereby taking up subject-responsibility: It was *my* child and *I* am responsible as a subject for *my* child's actions. BUT: taking up object-responsibility and hence subject-responsibility *I* constitute *my* identity, being a father, and constitute a social and group identity, this is the way *fathers (or mothers) should take up responsibility* (both in an object sense and a subject sense). Kant takes up the communitarian view here, namely by constituting selves one constitutes collective identities and reverse.

Now the issue is that the bond between those two forms of can be broken up: *I* might deny that *I* am the parent, *I* might deny that *I* am responsible for *my* child's actions (say he or she is 22 and has done something wrong, e.g. smoking in the presence of a pregnant women or living an ambitious life or becoming an addict), *I* might deny that the child is *my own blood*; or *I* might deny that the child in fact did it, that the window was already broken, that the local community does not provide a playing ground for hockey or soccer. In both directions, the parent severs the bond between subject and object responsibility, but also the parent constitute different identities: *I* am not the parent, *my* child is an addict or lunatic, the local community does not take care for children.

Besides the point that Kant agrees and would agree with liberals such as Locke and later on Mill and others that most of these affairs should be the affair of citizens and not of the state, that is, that the regulation of the interplay between subject and object responsibility should have the *judge of the public sphere* (and not government or any other public institution, whence a restriction on mandatory measures proposed by the public health community as an expert and public official laying down measures *top down* instead of promoting the capacity and vitality of the civil society), there is another point. This is, that in this back and forth process, identities are constituted and constructed.

4.3.5 Concluding remarks

In this review of Kant's philosophy and its potential for an ethics of public health, we have seen how Kant disposes with the *command and control* structure society, which typically featured in 18th century authoritarian Prussian society. Instead he asks for recognition of the morality of any top down politics and policy and the role of public officials in society. Although many public health professionals and experts would consider themselves at far distance of politics and bureaucracy – aren't they serving the *public*? – Kant is precisely addressing the issue how reasonable and just policies serving the public should be enacted. The underlying impetus can't be the principle of doing good, it should be accompanied by the judgment of justness. Just in Kant's term is quite different than notions of equity or fairness presuppose. It is about (indirect) consequences of actions outside the domain of control and care by communities and other forms of association. In this respect Kant's view on three points have been attempted to made clear:

1. his view on instrumental rationality: the setting of ends and correlatively the selection of preferable methods

^{xvii} This is taken from the philosopher Meir Dan-Cohen, who takes up on the one hand the Kantian view but on the other hand (what he claims) the social view; my point is that the crucial philosophical lesson of Meir-Cohen is perfectly in line with what Kant was aiming at.

2. his view on public and private (experts and officials) transcending the distinction between the individual and the social
3. his view on responsibility hereby constituting identities of individuals and communities

The bottom line of Kant's thought is to reject the top down, command and control structure of societal regulation. Instead he is *avant la lettre* proposing concepts of governance, voice and citizenship which are now quite important issues in contemporary political philosophy. In this sense the point of this paper is quite provocative: claiming that the rigid, principle based and duty freak kind of reading of Kant's philosophy should be reclaimed by a reading which focuses much more on the virtue based, anthropological and pragmatic side of Kant's philosophy, as well as on the importance of Kant as a political philosopher (reading his moral philosophy and philosophy of right in terms of his political philosophy rather than the other way around which is the received view, but which is commentated and has been substituted by the *new* reading following critics such as Allison, Wood, O'Neill, Herman, and many others.

Thus, Kant is putting emphasis here on the morality of political power. It is remarkable to see how Kant's work parallels Hirschman's work, who also puts much emphasis on the *producing forces* of knowledge, products and power. The issue for Hirschman is that many goods, private but certainly public goods, are *complex* goods. In most institutional domains such as health care, education, childcare, and labour arrangements, the quality of public products is not easy to determine. This applies the more so, when services are developing. In those cases it is unclear what is actually offered; there is no clear yardstick to determine *good care*, *good education*, etc. Participants do not know what they want, and in fact, producers of such services do neither. In such situations it is much more adequate to improve the functioning of these institutions: "*The reality of the situation is that demand for a service has arisen in advance of real knowledge of how to satisfy it ... the institutional question is here not of protecting the consumer, but of educating the producer and providing him with as much information as possible about his performance*".⁵⁵ So, we need to enact learning processes, but the focus is on the *producers* of social and political life and the institutional mechanisms to provoke voice.⁵⁶ In Kantian terms, it is about the power circles of social, economic and political life.

The other intriguing insight of Kant's philosophy is his presuppositions on the notion agency and responsibility. In a revolutionary way Kant forecasts already some of the extreme consequences of our notions on deed, risk, and moral worth developing now in our society and culture of risk, responsibility and social management. Kant was deeply involved in this area of concern, which seems to be highly relevant to the public health community and to current public health practice.

To finalize this point, already elaborated in this chapter, we may capture the famous case as presented by Augustinus, the Church Father, concerning committing adultery and marriage misconduct. He presents the case of the man versus his woman, but in our present world language it could also be a woman versus her husband, in which case the reasoning runs the other way, or it could also be two women or men. Probably not accidentally, Augustinus did not consider these situations. Here is the case Augustinus presents: A man in a hotel enters a room searching for the nice lady he saw in the lobby and ending up in bed with her. Another man enters a room looking for the same woman, but mistakenly he enters his own room and he ends up in bed with his own wife. The third man enters a room intending to go to bed with

his wife, but by accident enters the wrong room confronted with that same good looking woman of the lobby. Who is responsible for what in these three consecutive cases?

Similarly: I could meet an Italian, clearly visible pregnant woman and out of my anger with the Italian law, I light up my cigarette; I meet the same Italian woman but she is a happy smoker and responds to my lighting up the cigarette by smoking her own cigarette; and thirdly, I meet the same Italian woman, she smokes and asks me to light her cigarette, but I am penalized. Again, who is responsible for what?

The answer according to Kant has to be sought with reference to the social background for constituting and regulating individual and social behaviour. Indeed, smoking (or other forms of *bad behaviour*) can be considered a public affair, if enacted as a public issue: as external costs of (indirect) consequences of acts to others: this is the business of politics on his view. It is not the kinds of measures, by law or other enforcing regulations which form the centre of politics according to Kant. His emphasis is on the process through which we struggle to sort out what are public and private affairs with respect to the freedom of autonomous persons and communities. But we cannot discuss such issues without acknowledging the fact that in this process identities and responsibilities of selves and communities are created, shaped and reshaped.

Here comes the Kantian gist. As always Kant is putting upside down our *self-evident*, *common sense*, and *intuitive* feelings and notions: All our collective measures to reinforce people's sense of responsibility by making explicit public announcements on the various issues of responsibility – do not smoke, do not eat fat, do exercise, refrain from stress, and so on – are supposed to strengthen our identification with the appropriate sources of subject and object responsibility. However, while trying to reinforce our notions of responsibility, public health measures as representative of other collective, coercive measures, may in fact weaken it. If we learn that coercive measures apply to the operations of our free will, we may respond progressively contracting the latter's domain. The paradoxical effect here is that in many instances behaviour has to be moralized and blamed for: the person is an addict, the person has no control over his or her body and mind, the person has to be corrected. Increasingly we have to describe actions in a deterministic vocabulary designed to place our free will, our selves, and our communal life at the periphery of self and communal life, that is outside the boundaries of social life. This in fact leads to minimalist forms of constitution of selves and communities. Instead of accusing liberalism, as Kant actually already conceptualized in the 1790s (don't forget that there was a strong communitarian and communist as well as a libertarian countermovement against Enlightenment in the late 18th century, a period which we now consider as the *Golden Age of Enlightenment*) of creating atomistic individuals, liberalism should be seen on Kant's view as constituting selves, both individually and collectively. There is no other way. For, in some cases, we really need to restrict behaviour and to enforce legal sanctions as in the case of becoming murderers or terrorists – in which case there is a *direct link* between subject and object responsibility, at least a link which should be created according to Kant. However, in most cases, similar approaches may be unintended and unwelcome. If the mishaps associated with driving, smoking, eating fat, exercising too little, living too ambitious lives and other kinds of behaviours considered to be unresponsive to society's needs and goals, carry with them severe social and legal repercussions, we may decide to give up all sorts of social behaviour which are vital and creative to individuals and communities. By cutting down responsibilities, individuals and communities may draw the boundaries of their selves and their identities more narrowly than they otherwise would have done.

Then we end up in the paradoxical in which in the Anglo-American approach we would be astonished to learn that the person who deliberately refrains from pulling the drowning child out of the pond is not legally responsible for the child's death – which is in fact the legal case in the USA⁵⁷ – versus the situation in Italy where the person who lights up a cigarette in front of a pregnant women will be penalized.

4.4 Utilitarianism and Public Health

In contemporary bioethical literature it is customary for people not working in public health and not subscribing to utilitarian credos to hold that utilitarianism is the dominant theory behind public health. In this short enquiry into the relationship between the two it is acknowledged that while there is some trivial truth to the claim, for the most, it presents a gross over-simplification of the matter and can, in fact, be very misleading. The task in hand is made difficult by the fact that there is no one definition of utilitarianism, which, as a matter of fact, is a cluster of theoretical approaches that have been used to discuss a wide variety of issues from the proper treatment of animals to matters of economic efficiency. The normative content and depth of utilitarianism is to a large degree determined by the definition given to utility in any given approach, and further prescriptive variations are brought in by the different side-constraints laid upon utility calculations, which have been part of the doctrine throughout its history. The task of defining public health is not much more straightforward; politics, for one, has had great influence in determining the goals of public health, and even people currently working in the field do not to share a unified moral code. *“Today utilitarianism appears to be the dominant view of justice in medical and public health policy.”* (p15)⁵⁸

*“[Ethicists] have pointed out that the moral theory that underlies most public health actions is utilitarianism, which holds that actions are right in so far as they promote the greatest happiness (read: health) of the greatest number (p538).”*⁵⁹

The validity of claims like these depends on what we mean by utilitarianism and what we mean by public health. There are a number of ways to define public health, some of which simply emphasise a particular aspect of public health while some rule out competing definitions. Public health can, for instance, be said to be concerned with the health of the whole population and it can be seen as an attempt to reduce morbidity or mortality within the whole population. In this way it could be seen to echo the basic utilitarian ideals of impartiality (as opposed to any kinds of favouritism) and maximisation.⁶⁰ From the view point of public health authorities it needs not to matter who the individuals are, it is about the health of the population in general that public health is interested in. They are also clearly interested in the consequences of public health interventions in as much as the success of any public health policy is measured by whether it produces the intended benefits. In actual decision-making public health is a forward-looking venture; it is about whether this or that way forward will produce the desired end-results. This would, at the very least, seem to make public health a consequentialist project.

Utilitarianism tends to make comparisons between various courses of actions and deem one better than the other based on which of alternatives leads to the best end results with the lowest cost. Preventive measures are an important part of public health and the justification often used is that in the long term they form the most cost-effective approach. Warning people about salt, tobacco, fat and alcohol (provided that people listen) and banning these (provided that they obey) are more cost-effective ways of dealing with illness related to the over-indulgence of these substances than treating the diseases themselves.

Many other public health interventions are justified by variations of the utilitarian credo that we should aim at *the greatest happiness of the greatest number*.⁶¹ Vaccination programmes and water fluoridation schemes are justified by the health benefits to the many. The

occasional adverse effects are seen to be acceptable because of the benefits to the rest. Similarly the more drastic measures sometimes taken in the name of public health, like quarantine, are justified by the benefits to the many. Utilitarianism is often criticised for allowing the sacrifice of individuals in the name of benefit to the greatest number and here public health faces similar kinds of charges. This is an issue that divides the early utilitarians. The founder of classical utilitarianism, Jeremy Bentham might have allowed the sacrifice of individuals because of public health considerations, whereas John Stuart Mill, only a couple of decades later, found it necessary to restrict utilitarian considerations with those of individual liberty. While Mill might have allowed quarantine because of harm to others considerations, and would have allowed warnings on products known to be dangerous to one's health, he might have had a thing or two to say about banning self-harming goods and about other clearly coercive measures.

Side-constraints are also called for by today's public health authorities. Most feel that there are limits to the sacrifices that can be asked for in order to reach the greatest health benefits. Some lean towards the Millian ideas and think that individuals should have a role to play, and many others want to stress communal or cultural values instead.

Traditionally public health has been interested in decreasing morbidity and mortality and by doing so it has committed to a medicalised view of health. There is, however, a branch of public health, nowadays often called *population health* that has, instead of issues directly related to health and illness, concentrated on more general issues of poverty, inequality and lack of education. Some have seen this as an indication that public health is not committed to a narrow definition of health, but that it concerns itself with wider issues. Arguably, however, from the public health point of view, issues of injustice are to be tackled only in as much they contribute to the ill-health of the population and in that, it is the narrow definition of health that remains at the core of the matter.

The main normative difference between (most) utilitarians and those subscribing to the ideals of public health could be said to lie in the understanding of what the overall goal of our actions should be. Inasmuch as public health concerns itself with health only, it alienates many utilitarians who would hold that there is much more to *happiness* or *utility* than mere health.

The goals of our actions can in utilitarian theories be defined in many different ways. Some utilitarians go for the *natural* definition of physical pleasure, while others wish to include ideal or intuitive elements of a good life; some would argue that the goals can be include all non-fanatical preferences or rational desires, and yet others that what we really should be looking at are interests, well-being, or needs.⁶⁰ Utilitarian theories can also be classified as positive or negative, depending on whether the main aim is to maximise the identified good (positive utilitarianism) or to minimise the recognized bad, such as pain (negative utilitarianism). A further distinction in utilitarianism can be made between theories that are mostly interested in assessing the consequences of individual actions (act utilitarianism) and those theories which emphasise clusters of actions or general rules (rule utilitarianism). Economic utilitarianism is sometimes confused with moral and political utilitarianism, although the former is much narrower in scope.

If public health were utilitarian, it would most likely be described as objective and ideal, rather than subjective or preference related. That is, health as the goal is for the most given objective criteria and it is seen as an ideal. Whether public health would be described as

positive or negative utilitarianism will depend on whether the emphasis in the definition is given to reducing ill-health or to increasing the overall health. Public health tends to assess each intervention on its own merits which would fit better with the ideals of act utilitarianism than rule utilitarianism. To the degree that public health is interested in the cost-effectiveness of its methods, it comes closer to economic utilitarianism (this is sometimes called health economics) than to the moral and political forms of utilitarianism.

While there are utilitarians who subscribe to the ideas of public health, many do not. Preference utilitarians have problems with the objectivity of the definition of *the good* in public health, and even more utilitarians would find the idea of health as the main good to be promoted too narrow in scope. Those utilitarians with Millian ideas on the importance of individual liberty would find the paternalistic undertones of public health difficult to accept; and while most utilitarians would praise the impartiality of public health, many find its emphasis on the collective unsatisfactory.

If the key doctrine of public health is the greatest health of the greatest number, public health can be seen as a type of utilitarianism. However, on the one hand, most people working in public health would like to include some side-constraints to this simplistic dogma and, on the other, most modern utilitarians would be unwilling to accept the narrow and objective account of utility as *health*. There are normative and theoretical similarities between public health and utilitarianism, but to say that utilitarianism is the theory behind public health is to overlook countless subtle differences between the two.

4.5 Solidarity

Jørgen Husted⁶² made a distinction between two basic meanings of solidarity: *communal solidarity* where a group of people have a *common interest* and *constitutive solidarity* where people *have an interest in common*.

He further subdivided communal solidarity into *group solidarity* and *moral solidarity*.

4.5.1 Group Solidarity

Within group solidarity, the common interest is the *cement* or *organising principle* of the group. The members have a common interest in the sense that what is good or harmful to this interest is (or, at least, perceived to be) good or harmful to the individual too. Husted gave various types of group to which an individual could belong. For example, an ethnic minority, a profession, a creed, a unit of organised labour, local community. Group members demonstrate solidarity by standing by its weak and needy members in the sense of *looking after one's own*. However, this pattern of behaviour is more than just helping people in need, which could be valuable in its own right as a form of moral responsibility, as it is implicit or even explicit that this form of solidarity is in the common interest. As Husted points out:

“By recognizing its collective responsibility towards its needy members the group secures the loyalty of all members to the common cause and thus, also in this way, promotes it. In the same way the group is able to make legitimate demands on the individual to contribute their share to the lifting of the burden of the collective responsibility.”

4.5.2 Moral Solidarity

In situations where solidarity was not practiced for the common interest of an identifiable group, or only to a limited extent, Husted suggested that people may still demonstrate solidarity for the sake of the needy benefiting from it. In such circumstances, the act is out of individual moral responsibility rather than collective responsibility to a group. Instead of a defined group with shared aims and objectives there is a more general bond between individuals, a sense of *sharing a common lot* and *recognising oneself in the other*. Husted suggested that the basic principle underpinning this form of solidarity is *making the other person's cause one's own* out of a sense of duty.

Husted identified the following as important forms of moral solidarity:

- Brotherhood (sisterhood) solidarity: For example supporting others elsewhere in the world in disadvantaged political
- Charitable solidarity (neighbourly love or philanthropic solidarity): Provision of help out of a feeling of *doing unto to others as they would want done unto them* if they were also in need.
- Social solidarity: Willingness of well-off citizens to help the poor and needy via income redistribution.
- Egalitarian solidarity: Provision of social goods, for example health care according to need rather than ability to pay.
- Humanist solidarity: For example humanitarian aid following a natural disaster or in a war zone or protests against oppression of others.

4.5.3 Constitutive Solidarity

Unlike group solidarity where the focus is what is in the best interests of the group, and moral responsibility where the focus is on the best interests of needy individuals, *constitutive solidarity* (or *alliance solidarity*) is focused on the interests of the individual themselves. In this latter situation the individual realises that the best way to advance their own individual interest is to form an alliance with others to establish some form of collective agreement specifying the expected contribution to the collective and what they can expect back in return. Husted gave two examples of this. Firstly, workers may come together within a trade union to strengthen their ability to negotiate with employers by increasing the threat of industrial action. Individual workers would have a weak negotiating position as the employer could *pick them off* one-by-one. But if the entire workforce *stands together* and withheld their labour simultaneously the impact would be greater. In return for paying their union fees and abiding by agreed industrial action, if necessary, the employee is likely to get better pay and working conditions. The other example of constitutive solidarity, Husted also described as *entrepreneurial solidarity*. In this form of solidarity, individuals come together as stockholders to establish a company, with the goal of the individual increasing his or her own capital. Similarly, farmers could form a cooperative, for example to share equipment, marketing or negotiation processes with suppliers and customers.

4.5.4 Solidarity with who's interest?

While Husted draws a distinction between *common interest* and *interest in common* it may be more productive to categorise his three main forms of solidarity *group*, *moral* and *constitutive* according to the main interest being considered within each.

Within group solidarity, the main focus is on the best interests of the group. The individual is part of the group and benefits if the group flourishes, but it is the collective interest that is the main concern.

Within moral solidarity, the main focus is a third party individual and what doing things for them because it is the right thing to do. While there may be some expectation that others would act in the same way if the positions were reversed, in the pure sense of moral solidarity, the action is purely altruistic, and there is no expectation of personal reward of acting morally in doing the *right thing*.

Within constitutive solidarity, the main focus is the individual themselves. They are working with other people, and so indirectly assisting others to advance their goals but the focus is benefit to self.

4.5.5 Solidarity in the context of immunisation

Parents have obligations to act in the best interests of their children. There are some risks associated with immunisation, and some may contest that these risks outweigh the benefits. Most experts would agree that it would be in the best interests of a child to be immunised against various communicable diseases. The exception to this, is a small minority of children where immunisation would be unsafe due to a contraindication, for example a known allergy or some other medical condition. However, these children can gain some degree of protection against a communicable disease, if a high proportion of the population have been

immunised to prevent spread of the organism within the community – a situation described as *herd immunity*.

When a parent is asked to consider whether they wish to have their child immunised, their prime concern, quite correctly, should be the best interests of that child. However, they may also recognise an obligation to have their own child immunised in order to contribute towards achieving herd immunity and hence offer some degree of protection to those children for whom immunisation is contraindicated. Society could thus make a demand on parents to contribute to the goal of eradicating childhood infectious diseases through having their own children immunised. However, the concept of herd immunity is better considered as an example of constitutive solidarity. Within constitutive solidarity, the individuals may realise that the best way to promote their individual interest, or in this case the interests of their child, is to join with others to set up some form of collective unit. In other examples of constitutive solidarity there is usually a contract of some form, or some way of formalising the relationship between individuals. This is not the case in the context of herd immunity. Parents do not formally meet with other parents to discuss immunisation decisions. They may meet in passing at a health clinic or at the school gates and share information about their children, or ask for advice on immunisation. However, they do not formally agree to immunise their child if other parents do the same in order to increase herd immunity, as this would not be feasible across a whole cohort of parents.

Of course parents' decisions about one child could have implications for other members of their family. Thus immunising an older child could mean that they are less likely to bring home an infection from school and infect a younger, more vulnerable, sibling. In this situation the parent must consider common interests of the family (communal solidarity) and interests in common with other families (constitutive solidarity) not to infect each other.

4.5.6 Solidarity in the context of water fluoridation

There is a group interest in maintaining the health of group members in order that they can both flourish as individuals and make their contribution to their community. If people are suffering from toothache, and have to take time off work or are unable to function optimally in their various social roles, then this is not in the interest of the individual nor of the group. Other oral problems, such as gingivitis have been associated with other forms of morbidity e.g. as a route for infection. While there may be obligations to the group to look after oneself in order to contribute to the group interest, this in itself is not an argument for a policy of water fluoridation in terms of group solidarity. Poor oral health may have relatively small impact on the public health compared to cancer, heart disease etc., although dentists would legitimately claim that this morbidity is still of concern. However, given that oral health has generally been improving over the last few decades, a policy of artificial fluoridation may be difficult to support in terms of a group solidarity argument. Indeed, there would also be a *common interest* in not *harming* group members through causing fluorosis or other side effects that have been claimed (though not proven) from water fluoridation.

Group members demonstrate solidarity by standing by its weak and needy members in the sense of *looking after one's own* and in terms of water fluoridation the argument here is demonstrating solidarity with vulnerable children, who may not otherwise have access to sufficient fluoride to strengthen their teeth to take them into adulthood. Indeed, we could go further and state that we should show moral solidarity with children whose parents are unwilling or unable to provide that child with a source of fluoride. However, opponents of

artificial water fluoridation could argue that they are sympathetic to the needs of children, but could point to other effective mechanisms for ensuring that children have healthy teeth. For example, by supervising brushing of teeth or use of tablets/rinses in school, or provision of free/subsidised dental care. If delivery of fluoride by the water supply was the only means, or the overwhelmingly most cost effective means of the population having stronger teeth, then there could be said to be an *interest in common*. However, given the relatively easy and cheap access to fluoride by other means, it would appear difficult to use solidarity arguments to justify water fluoridation policies.

Anti-fluoridation lobby groups claim that forcing them to drink artificially fluoridated water, when there are no practicable alternatives (i.e. use of bottled water for all their fluid needs) is a breach of their civil liberties. Indeed, we demonstrate moral solidarity by respecting the civil liberties of others. However, making a claim that adding fluoride to the mains water supply, does not in itself mean that civil liberties have been infringed, nor that there are other more compelling rights and responsibilities.

4.5.7 Solidarity in the context of prohibition of smacking of children

Restriction on the smacking of children are justified on the basis of *looking after* children. Here the arguments for moral solidarity seem stronger than for water fluoridation. Smacking bans seek to protect the child from physical and psychological trauma. However, there is also a *common interest* in teaching children that certain behaviours are dangerous and also how to conduct themselves properly within society. However, there are other means to achieve this. For example, by explanation and verbal reasoning, rewards and more appropriate punishments. This said there is also scope for showing solidarity with parents, to support them, within reason, in allowing them to bring up their children in the way that they think to be most appropriate.

4.5.8 Solidarity in the context of banning smoking in public places

The public health impact of smoking related disease is more serious than poor oral health. The *common interest* is clearer: smoking leads to diseases such as heart disease, cancer, respiratory disease with associated morbidity and mortality, and this is not in the interest of the group. Smokers would therefore be under an obligation to place undue burdens on their fellow citizens due to lack of productivity or higher consumption of health care. Of course, a smoker could argue that if smoking cigarettes gives them enjoyment, or aids relaxation, which means that they are better able to fulfil their societal roles, then their habit does not impair the group interest. Similarly, they could argue that they are prepared to work harder or pay more taxes in lieu of other *personal pleasures* to offset any increased consumption of health care resources.

However, the main solidarity arguments in the context of smoking are not related to the harm to the individual smoker, but obligations on smokers to show solidarity with other members of the group who do not smoke. Thus, many of the bans of smoking in public places across Europe have been justified in terms of passive smoking and showing solidarity with vulnerable groups such as children, or occupational exposure to persons providing services to society e.g. by working in bars. Thus there restricting tobacco consumption demonstrates moral solidarity not to harm others through your actions.

Many smokers, aware of the health risks of cigarettes, wish to stop, but find difficulty in doing so because of the physical and psychological tobacco addiction. Being in an environment where they are surrounded by other smokers can be a challenge to their will-power to give up cigarettes. Thus people who wish to stop smoking, have an *interest in common* in creating environments where smoking is not permitted and hence they are not tempted to join other smokers. Thus, from within constitutive solidarity, people who wish to stop smoking are working with others people, and so indirectly assisting each other to advance their goal of becoming ex-smokers.

4.5.9 Solidarity in the context of *Not-in-my-Back-Yard* arguments

Within the EuroPHEN focus groups, citizens were asked to imagine that there were plans in their neighbourhood to build, a mobile phone mast, a home for people with mental illness or a chemical plant making everyday items, like plastic or pharmaceuticals. They were asked how they would you feel about this. Such planning proposals may generate protests from local communities against locating them in their neighbourhoods i.e. *Not-in-my back yard* or *NIMBY* arguments. The analysis of the focus groups will be presented later in the report, however in addition to *NIMBY* arguments where they were happy for the proposal to be built somewhere else, some people argued that *not in anyone's back yard* either (*NIABY*).

Consenting to the proposal for a home for people with mental illness, is a clear appeal to moral solidarity. People with metal illness and learning difficulty may be a threat to themselves and hence are vulnerable. It is therefore right to care for vulnerable people, who are ill through no fault of their own, just as we would want to be looked after if we needed such assistance. The fact that there is a very small (and often over exaggerated) risk of people with mental illness harming others, is of a lower magniture compared to our responsibility to fellow group members, although through providing the care and any treatment that they may need, the risk of them harming others is also reduced.

In comparison, the requirement for mobile phone masts is less clear in terms of solidarity. Effective communication is usually important for the smooth functioning of a group. However, it is doubtful that there is a common interest in mobile phone communication. Previous generations coped without such immediate forms of communication. Indeed, it could even be argued that frequent chatter about relatively trivial matters while sitting on a train, disturbing your fellow passengers is counter to the common interest. Any solidarity arguments in the context of a mobile phone mast, are more likely to take the form of constitutive solidarity. People have an *interest in common* in being able to use their mobile phone where and when they want, and hence must bear any negative consequences from the location of mobile phone masts in terms of aesthetics or potential harm from non-ionising radiation.

The location of a chemical plant would also appeal to constitutive solidarity: the vast majority want the products produced therefore we have to share the risks associated with their manufacture. (There are also benefits to the local economy in terms of employment). However, the danger with heavy industry associated with pollution, is that there will be inequalities, with some geographical areas bearing more of the risks of working in or living near polluting industry than others. Thus there are obligations to show solidarity to people living in deprived areas, who perhaps are more desperate for the employment associated with such industry, and to try to reduce the risks associated with the manufacturing processes.

4.6 Communitarianism

4.6.1 Communitarian criticism of Liberalism

Michael Sandel⁶³ critiqued the prevailing form of liberalism which is indebted for much of its philosophical foundation to Kant. He described this *deontological liberalism*, as follows:

*“‘Deontological liberalism’ is above all a theory about justice, and in particular about the primacy of justice among moral and political ideals. Its core thesis can be stated as follows: society, being composed of a plurality of persons, each with his own aims, interests, and conceptions of the good, is best arranged when it is governed by principles which do not **themselves** presuppose any particular conception of the good; what justifies these regulative principles above all is not that they maximise the social welfare or otherwise promote the good, but rather that they conform to the concept of **right**, a moral category given prior to the good and independent of it”.* (p1).

Liberal theories give priority to the rights of the individual above those of society. The individualists tend to distinguish between who one is and the values one has. Rawls²⁴ attempted to make this distinction in his description of the *original position* and the *veil of ignorance* in which participants are supposed to be ignorant of any information about their beliefs, norms, class, status, etc. Sandel⁶³ argued that the liberal vision of the individual as the autonomous chooser of his or her own purposes presupposes that the chooser is sufficiently sovereign over, and therefore distanced from them.

Communitarians believe that this conception of the self is illogical. A self that is as open-ended as the liberal conception requires would not be so much free as *identity-less*. Only a *thickly constituted self*, shaped in its very being by traditions, attachments, and more or less irrevocable moral commitments can actually make choices that count. Individualists fail to recognise that membership of a community is not necessarily voluntary, and that the social attachments which determine the self are not necessarily chosen ones.

4.6.2 MacIntyre’s Narrative approach

Alasdair MacIntyre⁶⁴, particularly in his book *After Virtue*, challenged the perceived ills of modernity, including modern moral philosophy and political theory. He believed that it was difficult to envisage each human life as whole because:

*“The social obstacles derived from the way modernity partitions human life into a variety of segments, each with its own norms and modes of behaviour. So work is divided from leisure, private life from public, the corporate from the personal. So both childhood and old age have been wrenched away from the rest of human life and made over into different realms. And all these separations have been achieved so that it is the distinctiveness of each and not the unity of the life of the individual who passes through those parts in terms of which we are taught to think and feel.”*⁶⁴ (p204)

Philosophical obstacles also arise, with a tendency to think *atomistically* about human action and to analyse complex actions and transactions in terms of simple components. The unity of a human life becomes invisible if a sharp separation is made either between the individual

and the roles that he or she plays, or between the different roles that an individual has, so their life appears as little more than a series of unconnected episodes. MacIntyre⁶⁴ gave the example of a man digging the garden and someone asking *what is he doing?* The answer could equally be *digging; gardening; taking exercise; preparing for winter; or pleasing his wife*. Some of these answers characterise the agent's intentions and others unintended consequences which he may or not be aware of. An action is always an episode in a possible story. And prior information is required about this man's behaviour is required to understand how these different *correct* answers related to one another.

MacIntyre⁶⁴ argued that one understands a person's life only by looking at his/her actions within a story, a *narrative*. In the example of the gardener, MacIntyre⁶⁴ places the activity both within an annual cycle of domestic activity i.e. of maintaining *household-cum-garden* but also as an episode within a narrative history of his marriage: two histories that happen to intersect.

Each person's narrative converges with the narratives of other people, who in turn become part of each other's narrative. The community (family, tribe, neighbourhood) sets up the form and structure for these narratives. Thus, MacIntyre⁶⁴ restricted his analysis of community to the family, the tribe and the neighbourhood. According to MacIntyre the modern state exhibits a confusion of values, lacking a shared understanding of the content of values and common moral beliefs, which are necessary for a community to be genuine cohesive unit:

*"In a society where there is no longer a shared conception of the community's good as specified by the good for man, there can no longer either be any very substantial concept of what it is to contribute more or less to the achievement of that good"*⁶⁴ (p232).

MacIntyre⁶⁴ recognised a role of fables and stories in teaching children *right from wrong* and *just deserts*. However, MacIntyre was embarked on a philosophical rather than purely a sociological enterprise nor an understanding of child development:

*"Man is in his actions and practice, as well as in his fictions, essentially a story telling animal. He is not essentially, but becomes through his history, a teller of stories that aspire to truth. But the key question for men is not about their own authorship; I can only answer the question 'What am I to do?' If I can answer the prior question 'Of what stories do I find myself a part?' We enter human society, that is, with one or more imputed characters – roles into which we have been drafted – and we have to learn what they are in order to be able to understand how other respond to us and how our responses to them are apt to be construed."*⁶⁴ (p216)

A narrative concept of selfhood has two requirements. Firstly, a person is what they may *justifiably be taken by others to be* in the course of living out a story that from their birth to their death. They are the *subject* of a history that is their own and no one else's, with its own peculiar meaning. Here, MacIntyre refers to the work of Derek Parfit⁶⁵ and others on the meaning of personal identity. However, it is MacIntyre's other aspect of narrative selfhood that is of more relevance to communitarian thinking. MacIntyre proposed that *"I am not only accountable, I am one who can always ask others for an account, who can put others to the question"*⁶⁴ (p218). I am part of their story, as they are part of mine. The narrative of any one life is part of an interlocking set of narratives. Moreover this asking for and giving accounts itself plays an important part in constituting narratives. Asking you what you did and why, saying what I did and why, pondering the differences between your account of what I did and

my account of what I did, and vice versa, these are essential constituents of all but the very simplest and barest of narratives.

The question of interest for MacIntyre was “*In what does the unity of an individual life consist?*”⁶⁴ Thus his analysis of a life in terms of narrative, led him to answer the question that “*Its unity is the unity of a narrative embodied in a single life*”⁶⁴ (p218). Hence to ask *what is the good for me?* is to ask *how best I might live out unity and bring it to completion*. Or to ask *what is the good for man?* Is to ask what all answers to the question *what is the good for me?* for all men (and women) must have in common. MacIntyre emphasized that it is “*the systematic asking of these two questions and the attempt to answer them in deed as well as word which provide the moral life with its unity. The unity of a human life is the unity of a narrative quest*”⁶⁴ (p219). These iterative and nested questions were also identified by Sandel who suggested that when an individual attempts to define their personal moral code they ask *who am I? how am I situated?* and *what is to my benefit?* as well as establishing *what is good for the community?*, because, as Sandel pointed out, we are “*partly defined by the communities we inhabit*” and are therefore “*implicated in the purposes and ends characteristic of those communities.*”⁶⁶

MacIntyre concluded that “*the good life for man is the life spent in seeking for the good life for man, and the virtues necessary for the seeking are those which will enable us to understand what more and what else the good life for man is*”⁶⁴ (p219). However he recognised that it was not possible to seek for the “*good or exercise the virtues only qua individual. This is partly because what it is to live the good life concretely varies from circumstance even when it is one and the same conception of the good life and one and the same set of virtues which are being embodied in a human life*”⁶⁴ (p220). MacIntyre⁶⁴ suggested that what is good for an Athenian general would not be the same as what it was for a medieval nun nor a seventeenth-century farmer.

4.6.3 The problem with Universalism

Here is perhaps one of the most controversial implications of communitarian theory. In order to be sustainable, moral principles should be congruous with the values and practices of the society in which they are to be applied. One of the consequences of this is that it may not be possible to conceive morality in universal terms. Universal and absolute justice, for example, may be another illusion of individualism. Since the values that people hold derive from their communities, it is feasible that concepts such as justice may not be universal or absolute, if each community has a different understanding of what such moral values entail.

As MacIntyre pointed out, it is not just that different individuals live in different social environments, but also because people approach their own circumstances as bearers of a particular social identity.

*“I am someone’s son or daughter, someone else’s cousin or uncle; I am a citizen of this or that city, a member of this or that guild or profession; I belong to this clan, that tribe, this nation. Hence what is good for me has to be the good for one who inhabits these roles. As such, I inherit from the past of my family, my city, my tribe, my nation, a variety of debts, inheritances, rightful expectations and obligations”*⁶⁴ (p220).

MacIntyre⁶⁴ suspected that this way of thinking would be an anathema from the standpoint of modern individualism which is founded on the ability of the individual *to be what they choose*

to be. Or an individual may acknowledge that they may be their parent's child or a citizen of a particular country, but they can choose whether they wish to be held responsible for the actions of their parent or the state. MacIntyre⁶⁴ pointed to how some white Americans deny responsibility for the effect of slavery upon black Americans by saying *I never owned slaves*, or how some Englishmen or Germans do not take any responsibilities for the historical problems in Ireland or in the 1930s-1940s, respectively, because all of that happened *before I was born*. Such attitudes attempt to detach the self from its social and historical roles. Such individualistic thinking is clearly at odds with MacIntyre's narrative view of the self in which the story of a life is always embedded in the story of communities in which an individual derives their identity. *"I am born with a past; and to try to cut myself off from that past, in the individualist mode, is to deform my present relationships"*⁶⁴ (p221). MacIntyre⁶⁴ was keen to stress that just because the self finds its moral identity within a community this does not mean that an individual has to accept the moral limitations of that particular community. These *moral particularities* are only a starting point from which to *search for the good, for the universal*. Here MacIntyre⁶⁴ rejects the concept of *universal maxims* as proposed by Kant, for example, as *"an illusion with painful consequences"*. He explains this by saying that *"When men and women identify what are in fact their partial and particular causes too easily and too completely with the cause of some universal principle, they usually behave worse than they would otherwise do"*⁶⁴ (p211). MacIntyre was critical of Hume account of virtue:

*"What Hume identifies as the standpoint of universal human nature turns out in fact to be that of the prejudices of the Hanoverian ruling elite. Hume's moral philosophy presupposes allegiance to a particular kind of social structure as much as Aristotle's does, but allegiance of a highly ideological kind. Hume thus provides ... an unsatisfactory underpinning for an attempt to claim universal rational authority for what is in fact the local morality of parts of eighteenth-century Northern Europe"*⁶⁴ (p231-2).

4.6.4 Walzer and Spheres of Justice

Michael Walzer⁶⁷ also argued that to search for unity is to misunderstand the subject matter of distributive justice:

*"In the matter of distributive justice, history displays a great variety of arrangements and ideologies. But the first impulse of the philosopher is to resist the displays of history, the world of appearances, and to search for some underlying unity: a short list of basic goods, quickly abstracted to a single good; a single distributive criterion or an interconnected set; and the philosopher standing, symbolically at least, at a single decision point"*⁶⁷ (p4).

Since the values that people hold are derived from the community in which they live, moral concepts and virtues such as justice, if they are differently defined and manifested in different communities, cannot be said to be universal or absolute.

4.6.5 Taylor and obligations to maintain social institutions

Charles Taylor⁶⁸, went further than MacIntyre and instead of seeing community as being important in interpreting the individual sphere, he believed that community was a precondition for moral autonomy. Taylor⁶⁸ believed that communitarians and individualist would all agree that we can only flourish as adults in relationship with friends, mates, children, and so on. But that individualists may claim that this had nothing to do with

obligations to belong to political society. Individualists may recognise involuntary obligations to parents, but these are obligations of gratitude, and parents are no longer essential parts of human development when we are ready to discharge these obligations. Similarly there are obligations to our children, to give them what we have been given. Taylor⁶⁸ also saw these as involuntary obligations, even though we may chose to have children or not, as we do not choose the genes and hence physical and psychological characteristics of our children during the natural reproduction process. Finally, there may be voluntary obligations to those with whom we have relationships through marriage, friendship, association etc. But these are obligations to specific people and so not necessarily involve continuing associations, and prima facie they do not represent obligations to belong and contribute to society.

Taylor⁶⁸ argued that even the extreme libertarian acquires the desire for individual autonomy by virtue of participating in a civilisation that has learned, over the course of many centuries, to put a premium upon such aspirations. Taken out of a social-historical context, the very desire for control over one's autonomy would be void of meaning. Therefore, precisely those aspirations that define the autonomous individual are the expression of a debt to one's society, and hence represent social obligations, that are overlooked in libertarian theories.

*"Now, it is very dubious whether the developed capacity for this kind of autonomy can arise simply within the family. Of course, men may learn, and perhaps in part must learn, this from those close to them. But my question is whether this kind of capacity can develop within the compass of a single family. Surely it is something which only develops within an entire civilisation"*⁶⁸ (p43).

Taylor⁶⁸ believed that humans are not born with the desire to be an autonomous agent. They have to acquire it, but this is not achieved in every society, nor do all members of a society (which provides the environment for nurturing such capacities) fulfil their potential. The free individual can only achieve and maintain his identity in a certain type of culture. Taylor thus pointed to an obligation to engage in society to maintain and develop the rights so valued by libertarians:

*"We live in a world in which there is such a thing as public debate about moral and political questions and other basic issues. We constantly forget how remarkable that is, how it did not have to be so, and may one day no longer be so. What would happen to our capacity to be free agents if this debate should die away, or if the more specialized debate among intellectuals who attempt to define and clarify the alternatives facing us should also cease, or if the attempts to bring the culture of the past to life again as well as the drives to cultural innovation were to fall off? How long would we go on understanding what autonomous choice was? Again, what would happen if our legal culture were not constantly sustained by a contact with our traditions of the rule of law and a confrontation with our contemporary moral institutions? Would we have as sure a grasp of what the rule of law and the defence of rights required?"*⁶⁸ (p44).

Taylor argued that:

"The free individual of the West is only what he is by virtue of the whole society and civilisation which brought him to be and which nourishes him; that our families can only form us to this capacity and these aspirations because they are set in this civilisation; and that a family alone outside of this context – the real old patriarchal family – was a quite

*different animal which never tended these horizons. And I want to claim finally that all this creates a significant obligation to belong for whoever would affirm the value of this freedom; this includes all those who want to assert rights either to this freedom or for its sake”*⁶⁸ (p45-46).

He rejected the argument that after becoming an adult with the capacity to be an autonomous then there were no further obligations to sustain the civilisation that helped to nurture those capacities, in the same way as obligations to parents can be *time-limited*. Taylor doubted whether:

*“We could maintain our sense of ourselves as autonomous beings or whether even only a heroic few of us would succeed in doing so, if this liberal civilization of ours were to be thoroughly destroyed ... Future generations will need this civilization to reach these aspirations; and if we affirm their worth, we have an obligation to make them available to others. This obligation is only increased if we ourselves have benefited from this civilisation and have been enabled to become free agents ourselves”*⁶⁸ (p46).

Walzer argued that it is not possible to talk about justice without considering the sorts of goods that a particular society distributes among its members.

*“Distributive justice is a large idea. It draws the entire world of goods within the reach of philosophical reflection. Nothing can be omitted; no feature of our common life can escape scrutiny. Human society is a distributive community. That’s not all it is, but it is importantly that: we come together to share, divide, and exchange. We also come together to make the things that are shared, divided, and exchanged; but that very making – work itself – is distributed among us in a division of labor. My place in the economy, my standing in the political order, my reputation among my fellows, my material holdings: all these come to me from other men and women. It can be said that I have what I have rightly or wrongly, justly or unjustly; but given the range of distributions and the number of participants, such judgements are never easy”*⁶⁷ (p3).

Walzer claimed that:

*“...different social goods ought to be distributed for different reasons, in accordance with different procedures, by different agents; and that all these differences derive from different understandings of the social goods themselves – the inevitable product of historical and cultural particularism”*⁶⁷ (p6).

This claim contains two elements. Firstly, the idea that different goods constitute different distributional spheres within which it may be appropriate to have alternative means of allocation. The distribution of good such as health care would therefore be in accordance with the particular principles appropriate for health care and should not be corrupted by other goods, such as money, that properly belong to other spheres. The second claim relates to different understanding of the social goods themselves which are socially constituted by shared experiences, communal meanings, and traditions of self-understanding that evolve through history. Therefore liberal justice cannot presume to maintain neutrality toward ends and goods, as the very individualist rights and goals that they seek to protect are made available to the self via a process of communal definition that is *not* at the disposal of individuals.

Rousseau believed that citizens ought to love their country and in turn, their country ought to give them some reason for doing so. Thus he asked:

*“How shall men love their country if it is nothing more for them than for strangers, and bestows on them only that which it can refuse to none?”*⁶⁹

4.6.6 Communal provision

This was a theme important to Walzer in his account of membership, which he believed was “important because of what members of a political community owe to one another and to no one else, or to no one else in the same degree”⁶⁷ (p64). Walzer also stated this in reverse by saying that “communal provision is important because it teaches us the value of membership”⁶⁷ (p64). Hence if there was no reason for community members to provide for one another, there would be no distinction between members and strangers and hence no reason for people to form and maintain political communities. The first thing that they owe one another is communal provision of security and welfare. Communal provision may be *general* or *particular*. Walzer⁶⁷ said that it was *general* whenever public funds are spent so as to benefit all or most of the members without any distribution to individuals. It is *particular* when goods are actually handed over to all or any of the members. Securing the food supply is *general* whereas distribution of food to the poor or malnourished is *particular*. Walzer⁶⁷ suggested that Public Health is most often *general*, whereas individualised clinical care is *particular*. Public health is *general* communal provision when it utilises population approaches e.g. information campaigns, mass water fluoridation etc. The establishment of immunisation or screening programmes would be *general* since they are designed to meet the needs of the community as a whole. The provision of the screening tests and vaccines to individuals would be *particular*, especially if targeted at particular age ranges or vulnerable groups. Restrictions on consumption of drugs, alcohol and tobacco, could be portrayed as meeting the *needs* of individuals who use them, or consume them in too high quantities. However, arguably such restrictions are something that the rest of us need, to protect us from the effects of drug-related crime, passive smoking or drunk drivers.

While Walzer⁶⁷ used Public Health as an example of *general* provision, he recognised that it is provided at the expense of some members of the community, in particular it benefits most (usually), the most vulnerable members of the community. For example, health and safety regulations covering housing under multiple occupation, or anti-pollution laws for people living in industrial areas. The benefits, therefore are not strictly speaking mutual. Walzer⁶⁷ stated that every serious effort towards communal provision, insofar as the wealth of the community derives from the assets of its members, is redistributive in character.

According to Walzer, the social contract is:

*“... an agreement to redistribute the resources of the members in accordance with some shared understanding of their needs, subject to ongoing political determination in detail. The contract is a moral bond. It connects the strong and the weak, the lucky and the unlucky, the rich and the poor, creating a union that transcends all differences of interest, drawing its strength from history, culture, religion, language and so on. Arguments about communal provision are, at the deepest level, interpretations of that union. The closer and more inclusive it is, the wider the recognition of needs, the greater the number of social goods that are drawn into the sphere of security and welfare”*⁶⁷ (p82-3).

The exclusive pursuit of private interest erodes the network of social environments on which we all depend. The ability of an individual to exercise their autonomy depends upon the active maintenance of the institutions of civil society where citizens learn respect for others as well as self-respect. Similarly community flourishing is dependent upon the contribution of its members to shared projects. The relationship of private and public interest is manifested by a mesh of complimentary and reciprocal rights and duties. There is a recognition that there are common challenges faced by members of a community which can be addressed by common thought if not common action, with a spirit of solidarity to provide a voice and support for less well situated community members.

4.6.7 Applying Communitarian approaches within Liberalism and Kantianism

However, it should not be seen as impossible that the more traditional ethical positions of liberalism, Kantianism, utilitarianism etc. may be able to structure this communitarian idea in a way that makes the tensions between individual and public interest manageable. Indeed, Durkheim attempted just such a revision of prevailing liberal and Kantian thinking. The connection between the individual personality and social solidarity was of interest to Durkheim who described how *“the individual, whilst becoming more autonomous, depends ever more closely upon society... In social life everything is individual, because society is made up only of individuals ... But because individuals form a society, new phenomena occur whose cause is association, and which, reacting upon the consciousness of individuals, for the most part shapes them. This is why, although society is nothing without individuals, each one of them is more a product of society than he is the author.”*⁷⁰

Durkheim suggested that there are two extreme positions around which moral theories can be grouped. Liberalism views the individual as a radically autonomous self. Communitarianism views the individual as socially determined.⁷¹ Durkheim is often portrayed as a theorist of group solidarity and social order with no sympathy towards the individual. However, he explored ways to express the normative relation between the private and public that would avoid reducing it to one of these contrary positions. In so doing he attempted to defend liberalism from egoism, and communitarianism from fatalism, and the assimilation of the individual into the social mass. His aim was a social theory that articulated and defended individual dignity and rights within a social tradition that valued the common good. In his essay *“Individualism and the Intellectuals”*⁷², Durkheim conceded that some varieties of liberalism are egoistic and encourage individuals to become excessively preoccupied with self-interests and hence threatening the common good of society. He was critical of some forms of liberalism which we described as a *cult* which see liberty as an *idol* for which they will *willingly sacrifice all else*⁷².

However, Durkheim⁷² did not accept that utilitarianism provided a way forward. While utilitarian purports to achieve the greatest happiness for the greatest number, Durkheim believed that it described a society that was no more than a group of disparate individuals pursuing external goods such as wealth, status and power. Here, Durkheim was taking a very narrow view of utilitarianism and did not explore the perspective of Utilitarians, such as Mill for example, who placed great value on the utility associated with individual freedom. Indeed, Utilitarians can also choose to value social goods associated with living and participating in communities. Thus, while Bentham described the community as *“a fictitious body, composed of the individuals who are considered as constituting as it were its members”* and went on to

say that the interest of the community is “*the sum of the interests of the several members who compose it*”⁷³, a utilitarian calculation does not need to be so restrictive.

Durkheim⁷² described another form of liberalism that he called *moral individualism* that is both moral and social. He was clear that *all communal life is impossible without the existence of interests superior to those of the individual*. Durkheim⁷² attempted to locate his beliefs within a republican tradition that describes rights and responsibilities arising from a commitment to public, not only to private concerns. The *moral individual* was an active member of a political community whose obligations and desires are directed toward the community and whose benefits, in turn, are protected by society. Thus there is no fundamental conflicts between private and public interest. Writing just over a century after the French revolution, at a time of political uncertainty in France, Durkheim⁷² and other writers were concerned about a slide towards political anarchy. Durkheim⁷² believed that those who advocated threatening the rights of the individual is more likely to be anarchy because they threaten the moral and social traditions that bind citizens together within a society. An overly restrictive society also denies the individual of much that makes his or her life worthwhile.

4.6.8 Communitarian defence of Privacy

A private interest in maintaining privacy may appear to be conflict is with that of the public interest. However, taking the approach of Durkheim it is possible to argue that not just liberalism values individual privacy.

Privacy may have a narrow or a wide definition⁷⁴. In its narrow formulation it relates exclusively to personal information about an individual and the degree to which third parties have access to this information. In an even more restricted definition there is a requirement that this information should be *undocumented*. Thus, if all information about an individual were published in the public domain, it would be impossible to infringe privacy, although there would be no privacy to invade because there would be nothing that was kept secret. Similarly, the concept of privacy would be meaningless if stranded alone on a desert island, as there would be no one from whom to keep things secret. In its widest sense privacy extends beyond control over information (*informational privacy*) to include *decisional privacy* and *physical privacy*.

The concept of *private* is both norm-dependent and norm-invoking, and hence the boundaries of privacy will vary from one culture to the next. In some societies, cutting oneself off from a collective experience could be seen as cheating others of their right to share in it.

Privacy is integral to our understanding of ourselves as social beings within varying kinds of relationships. Having a private life is central to the development of a personal identity. Thus, we may adopt apparently different identities in different circumstances, at home, work, during leisure/social activities. These different *personas* are not hypocritical. Privacy is crucial to the individual's ability to maintain various kinds of relationships. For example, a couple of lovers may be intimidated from being intimate if observed by a third party. Such a concept of privacy is wider than relating purely to confidentiality (informational privacy). However, intimacy is not merely the sharing of otherwise withheld information. The context is also important. For example one may reveal personal information to a doctor that one may be reluctant to share with friends, family or a lover. But this does not necessarily mean that one has an intimate relationship with the doctor. Privacy is closely related to fundamental ends

and relations such as friendship, trust and love. Not only is privacy a means for advancing these relationships, without privacy they are inconceivable. Thus, when two people are in love with another person there is a process of spontaneous and mutual relinquishment of certain rights, which goes beyond mutual respect, in order to create a new shared domain of interest, defined in terms of their relationship. Friendship can be seen as another sphere, which differs from love only in the degree to which the relationship is central to the lives of the individuals concerned. The exchange of privacy rights will be accordingly reduced, depending on the strength of the friendship or acquaintance.

Privacy should not be a negative concept whereby the individual is left alone and becomes isolated. If privacy is to be worthwhile it should enable the individual to be an active member of society with a range of social relationships. To this extent, despite arguments that privacy is a fundamental human right, privacy should be a means to an end. When we voluntarily grant others access to our private sphere, this is an *exercise* of right to privacy not a *waiver* of that right. We exercise our right to privacy in order to advance other goals. It is for this reason that an account of privacy incorporating love and respect is attractive: if we love, hoping to be loved in return, perhaps we should consider the common good in order to have our own interests recognised.

4.7 Ontological Personalism and Public Health

4.7.1 The various meanings of philosophical personalism

Personalism is a wide-ranging cultural movement which can be divided into several trends from a philosophical viewpoint. However, the philosophical trend described and analysed below is ontologically-based personalism along the lines of Thomas Aquinas⁷⁵ and J. Maritain⁷⁶ (in this chapter, for simplicity purposes, the word ‘personalism’ is often used: it is understood, however, that reference is always made to ‘ontological personalism’). From this point of view the individual is a subsisting substratum who reveals himself not only in a phenomenal event, but transcends his own manifestation in the inexhaustible richness of his spiritual being. The intention here is not to underestimate the contribution of other philosophical approaches, but rather to integrate them by acknowledging the human being’s substance as being a priority. The person is relationship to self (presence of self to self) and hetero-relationship (with the world and with others), but is not limited to the relational structure: the subjective-relational aspect does not fully explain the concept of human person because subjectivity presupposes a source to express itself, a being which unifies and vivifies the multiplicity of expressions and acts. The human being, capable of intellectual ability, conscience and freedom is also a spiritual being, an active source of spiritual nature which founds and demonstrates his operational capacities (pertaining to his nature) without limiting himself to them, in the same way as individual free acts do not correspond to freedom *tout court*, or individual thinking acts to the intellect. The capacities are not always active and therefore do not fully express their source; acts are changeable and contingent, leading back to the source of the permanent and unchangeable personal being which manifests their implementation, while at the same time being richer than the phenomenal event itself. The traditional philosophical principle of ‘*operari sequitur esse*’ expresses the need for an ontological foundation of the subject, highlighting the prevalence of being over acting.

Applying the ontological approach to medicine and to biomedical sciences in general means not to expose corporeal features to objective external factors, defining as persons in their own right all individuals regardless from their ability⁷⁷.

4.7.2 Differences between ontological personalism and a Kantian perspective

The specificity of the ontological personalism, is that it justifies its own ethics by a not to be set aside metaphysical dimension. Of course, the roots of such a position are to be found in the Greek philosophy characterized by a finalistic vision of the world and, therefore, of man. It is just in these characteristics and roots that ontological personalism substantially differs from apparently similar currents of thought such as communitarianism or Kantianism. The reason why ontological personalism cannot be confused with Kantian deontological ethics is that the latter appears as a formal ethics, with an immanent dimension whose foundation is man, even if in his rational and relational nature. In ontological personalism, the foundation of ethics is a transcendent source identified with a natural order of things which man is part of. That order can be clearly found in the very human nature. Therefore, the call to the metaphysics is fundamental and constitutive in ontological personalism and it avoids relativistic attitudes and solutions that can occur, on the contrary, in a Kantian perspective in which the concepts of society and culture maintain their importance in defining ethics.

4.7.3 The human person as a foundation of ethics

The centrality of the human person features in the universe, in society and in history because he sums up and gives meaning to the world's existence, he is the centre of society (which is made by people and for people) and finally he is the creator of history, whose source and explanation can be found in individual persons, their relationships and their actions.

The human being, however, is also the basis and criterion of ethics. The person is the criterion of ethics in a subjective sense because an action is ethical whenever it expresses a personal choice, but also in an objective sense because the person is the foundation, measure and goal of the moral action. In other words, an action is ethical if it fully complies with the dignity of the human person and the values which are intrinsically inscribed within its nature.

In addition, the value of the human person resides in its relationship with a transcendent dimension, a 'creating Being'. Therefore, irrespectively of his qualitative and functional connotations, the person is worth in itself, just as such. The existence is a received and not a chosen good: hence it follows the impossibility to hold man as the absolute master of his own life, with all its consequences in bioethical matters. In other words, in ontological personalism the strong and structural dependence of man from the *ordo creationis* drastically limits man's decisional power.

This substantialist consideration leads to a perfect identification among the concepts of 'human being' and of 'person' that in other currents of thought appear, on the contrary, autonomous and not always identifiable.

An action is legitimate and morally approvable if, starting from awareness in choice, it respects the person and helps make his being and growth perfect. According to personalism, therefore, a core of structural elements exists in relation to human beings and to the natural order which have universal features and represent the reference point for moral rules. Our view of the world, of others, of history, may change and require new categories of interpretation (in this sense one could literally speak about 'pluralism'), but the truth about humans is objective and independent of recognition by humans themselves: this is why human rights can be conceived as universal, that is, belonging to all human beings merely on the basis of being human, without any other determination of sex, race, religion, state of health, etc. From this viewpoint, human life is regarded as a fundamental asset, inviolable and untouchable because 'it represents the condition of the human being itself, that is to say the prerequisite without which there is no individual',⁷⁸.

4.7.4 Ontological personalism in life sciences and its principles

The previous paragraphs underline that human life is regarded by personalism as an essential asset 'in the sense that it represents the human condition itself, that is to say the prerequisite without which the individual cannot exist',⁷⁹. Hence the identification of personalism with the theoretical model of the sacredness of life which is rooted in the principle of the inviolability of human life. From this perspective personalism is different from the medical and bioethical trends of a contractual kind because it starts from a 'strong' position which allows no derogations and, most of all, no 'interpretations'. The utilitarian-contractualistic positions, on the other hand, are based on the search for a consensus on minimal bases using a top-down approach towards fragile consensus bases, founded not on philosophical-rational assumption, but merely on conventions. Such approaches are characterized by a more pragmatic theoretical foundation that, on one hand, satisfies the practical demands of public health but,

on the other, tends to sacrifice the ontological depth of man to materialistic logics that show little regard for the anthropological factor.

These assumptions lead to the basic principles of personalism which affect medicine and bioethics and are rooted in the concept of corporeity seen as a co-essential dimension and incarnation of the person⁸⁰.

It should be pointed out that, from a personalistic perspective, not all principles have the same relevance, but a substantial hierarchy is recognized, where the summit is occupied by human life as a non-negotiable value. This is due to the fact that an individual's life is regarded as a good not comparable to other goods or values and it therefore cannot be analysed in quantitative terms.

4.7.5 The principle of respect of physical life

This entails respect for the life of each human being, stating that the latter is inviolable and untouchable from the moment of conception, as a fundamental and irreplaceable individual value. Physical life is the most important among empirical assets which comes before and leads to all other assets and values. Hence any type of reduction of the human body to an object are regarded as an offence to human dignity.

4.7.6 The therapeutic (or totality) principle

It defines the conditions of ethical admissibility of medical intervention on the human body: acting on the part where disease is located to save a healthy organ, where there is no less invasive nor less destructive therapeutic action, given there is a reasonable likelihood of success, and having obtained the patient's informed consent.

4.7.7 The principle of liberty and responsibility

Within the framework of personalism, the principle of autonomy cannot be applied universally because, as stated earlier, it is limited by the principle of respect for physical life and enhanced by the responsibility ensuing from freedom itself. As opposed to the patient's principle of self-determination, the doctor's prerogative is acknowledged thus leading to the right to conscientious objection.

4.7.8 The principle of sociality and subsidiarity

This principle is probably the most relevant in terms of public health policies. It states that the common good should be pursued through every person's good and cannot be in conflict with an individual's good. If there is a conflict between them the hierarchy of the principles mentioned above shall assist in making a choice. According to the principle of sociality, individual life and health are personal but also social assets. The subsidiarity element, on the other hand, concerns the allocation of resources and the organisation of health policies; it requires that all members of the community, wherever possible, are granted equal access to treatments that are necessary and available (social justice), but also that those who need such treatments are helped most. The implication is therefore an approach to health policies based on solidarity, on the criterion of urgency, proportionality of treatment and causal selection.

4.7.9 The strongholds of ontological personalism

Some of the proposals put forward by personalism are particularly relevant in terms of public health ethics. Four aspects are worth mentioning in particular: respect for life; sociality and solidarity; responsibility; the therapeutic principle referred to communities^{81,82, 83}.

4.7.10 Respect for life

The duty to respect life can be interpreted in different ways, but the aim here is not to describe them in detail. For the purposes of this paper the most relevant aspect is the social and solidarity element of respect for life. Over time several meanings have been attributed to this expression.

Public health actions that are not aimed at protecting life and health are useless or ineffective and, in this sense, unethical.

This position can even be shared by those who do not consider life as having sacred character. As a matter of fact, it is a position also accepted by those who refer to the *postmodern* concept of *well-being ethics*, thus attributing particular importance to the so-called *quality of life*⁸⁴. *Well-being* and *quality of life* can indeed also include values such as respect for life and ‘*integrity*’, that is to say *leading life in accordance with the values that count*⁴⁴. The ethics of *quality of life*, however, inevitably clashes with the ethics of *sacredness of life* if the value of *life* is considered as being gradual, which means that it becomes the basis for economic-health choices. Such an approach inevitably goes against the principle of the inviolability of human life, paving the way for arbitrary discrimination.

4.7.11 Sociality and solidarity

If the values of sociality and solidarity are important for the whole of bioethics, this is all the more true in the case of public health. Sociality and solidarity in public health can be expressed in different ways. In chapter, the chapter on solidarity, the basic meanings of solidarity according to Jørgen Husted are described. Within ‘group solidarity’, the main focus is on the best interest of the group. Within ‘moral solidarity’, the main focus is a third party individual and doing things for them because it is the right thing to do. Within ‘constitutive solidarity’, the main focus is the individual themselves. ‘Group’ and ‘moral’ solidarity are, according to Husted, two expressions of ‘communal solidarity’, where a group of people have ‘a common interest’. The author distinguishes it from ‘constitutive solidarity’, where people ‘have an interest in common’.

Personalism emphasizes the positive and moral value of solidarity, and considers it both an ethical-social principle, and a virtue. According to personalism, solidarity is an other-directed behaviour, which places the interest of others ahead of one’s own interest; it is *purely altruistic, and there is no expectation of personal reward*. Therefore, following Husted’s distinction, it might be considered a kind of *moral solidarity*.

Morally good action requires not only a good act, but also good circumstances and a good intention. This rule, derived from Thomas Aquinas’ ethics, is an integral part also of solidarity. Circumstances and intentions are necessary to mark out an *altruistic* act as morally good: the act, uprooted from circumstances and intentions, can easily be part ultimately selfish not in conformity with the entire good.

Solidarity highlights the intrinsic social nature of the human person, the equality of all in dignity and rights and the common path of individuals and peoples towards an ever more committed unity. According to personalism, solidarity is not a feeling of vague compassion, but a firm and persevering determination to commit oneself to the common good, because we all are responsible for all. Personalism recognizes the intimate bond between solidarity and the common good and between solidarity and equality among men and peoples.

Referring to public health, this can be expressed mainly in two directions. First of all there is factual solidarity which the community is called upon to express towards vulnerable and disadvantaged groups. The second approach goes in the other direction and concerns the duties which individuals have to carry out in order to conform with those public health standards and which every person has to follow.

The first method is an obvious characteristic of public health, the second is probably less. However, it is important to note that if it were absent, public health would probably be nothing more than patronizing on the part of Governments. The protection of public health, on the contrary, also involves creating awareness among individuals, as well as people giving up part of their independence in favour of the common good⁸⁵.

According to Buchanan, “*responsibility arises wherever individuals accept as personal concerns something which society presents to their attention*”⁴⁴ (p166). Clearly, sociality should not be reduced to blind compliance with norms on the part of individuals. In Priester’s opinion every public health system ‘should generate a sense of community. Social solidarity means a commitment to reducing the gap between the different segments in society, integrating them into a community’⁸⁶. Bard also mentions integration, though interpreting it as a need for bioethics and public health to meet if we accept the idea that occurs quite commonly in literature on the subject, that a prerogative of bioethics is respect for individual rights, regardless of the best interest of the community which, on the other hand, remains the primary objective of public health⁸⁷.

4.7.12 Responsibility

Another area of values closely related to sociality and solidarity concerns personal responsibility: “*if there is a right to health assistance, there should also be a duty to respect it*”⁸⁸. This duty is one of the expressions of responsibility. Responsibility can also be expressed in many ways in public health. Three ways should be mentioned in particular.

First of all, there is the responsibility, wherever possible, to prevent and protect from avoidable diseases and, more generally, to accept the indications given to all citizens on the subject of behaviour and lifestyles.

The second is connected to the first responsibility and relates to the duty of not creating burdens for society by irresponsibly taking the risk of becoming ill.

The third duty is to support people in need, as mentioned above with respect to solidarity and sociality.

As regards responsibility, it is also important, from an ethical viewpoint, to find a balance, seeking to avoid excesses. The most evident excesses are ‘making the victim feel guilty’ (in

the case of people whose behaviour is at risk) and the deregulated freedom of choice regardless of duties⁸⁹.

Since public health is aimed at the community, mention could be made not only of responsibility which is a fundamental aspect of bioethics in general, but of *co-responsibility*, with reference to the overlap between individual and collective responsibility: if “*individual freedom stops on the border with privation of liberty for individuals taken collectively*”⁹⁰ and if “*collective responsibility is much more than the sum of individual responsibilities (and) expresses a change in relationships in the expression of responsibility, the shift towards a higher level of knowledge*”⁹¹, it is clear that “*the opposition of the two concepts represented by individual responsibility and collective responsibility would be absurd and the result would be a Manichean concept where one of the terms is in a privileged position compared to another*”⁹².

4.7.13 Individual health and public health: the therapeutic principle

Scientists and philosophers seem to concur on a concept of health which ‘is not reducible to a mere neutral description of well-functioning of a being, but means at the same time a certain kind of good *of* and *for* being’⁹³.

*‘Public health has a clear utilitarian or consequentialist component. It aims to promote human welfare and reduce human misery, and is solidly based on factual evidence. At the same time, it is limited by Kantian or deontological considerations, such as respects for persons and their rights. The hard question arise when individual rights clash with the general welfare’*⁹⁴.

From a public health perspective, the challenge for the therapeutic principle is to find a balance between personal freedom and promotion of good health for the community: both personal freedom and goals shared by community are social values. Therefore it is necessary to resolve the question about how well-being is to be understood for public policy⁹⁵.

An answer is offered by E. D. Pellegrino and D. C. Thomasma: ‘The clinical relationship centers on a vulnerable, anxious, dependent often suffering individual person. By offering to help, the clinician ‘professes’ to possess medical knowledge that [he/] she will use for the patient’s good. The clinician serves the common good by [his/] her dedication to the good of individual patients. Clinicians, physicians, and nurses are *de facto* advocates for the good of their patients. For public health physicians and nurses the relationship is with the whole society. The end or purpose of the relationship is the good of humans as collectively, the common good. Public health physicians act for the good of all to the extent that medical knowledge can serve that good. They are *de facto* advocates for the common good. Their ‘patient’ is society and its ills: they serve the good of society’s individual members secondarily by assuring a health community in which the individual can flourish’⁹⁶.

4.7.14 Conclusion

The concept of human rights presupposes that some basic principles transcend cultural diversity. The major challenge consists in identifying those universal principles which regard public health.

Ontological personalism founds its philosophical system on the human value, in a global and integral sense. This view is different from other similar approaches, which, however, also lead to diverging conclusions on the subject of ‘bioethics and public health’, hence some fundamental principles which constitute its solid pattern of interpretation. In other words, ontological personalism is not opposed *a priori* to approaches which today represent the main philosophical foundation of public health, but it tries to provide a ‘strong’ anthropological background as a reference. The same principles which North-American bioethics defined as guidance firstly for clinical decisions and then also for health policies, are incorporated by personalism, but integrated and re-elaborated within a ‘foundational’ perspective, not simply as an offer of equivalent alternatives. This is shown, for example, by the hierarchy of principles which is indicative of a precise and consistent philosophical background. The latter might be in conflict with ‘useful’ choices in a society which is increasingly attentive to spurious factors, such as efficiency and economics; in any case, it guarantees the value of the human person, not only and not so much because this is useful for society, but on the basis of the value of the individual *per se*.

The substantialist interpretation of the human being implies a specific relationship between the good of the individual and that of the community. The common good or, in utilitarian terms, the good of the majority, cannot pass through the negation of the fundamental rights of the individual. At the same time, however, each person, according to the principle of sociality, realizes herself “*sharing the realization of the good of other persons. In the case of the promotion of life and health, this involves that every citizen commits himself to consider his own life and that of other people not only as a personal but also as a social good. It binds the community to promote the life and health of everyone, to promote the common good promoting the good of everyone*”⁹⁷.

Personalism can help to create a synergy between the good of society from a medical point of view that results from the application of medical knowledge to cultivate the health of society as an organism, the good of society as society perceives it, the ontological good of society and the spiritual and non-historical good. According to ontological personalism, human nature in the entirety of its complexity is the criterion of morality, both at an individual level (clinical ethics) and at a collective level (public health ethics). This perspective can also furnish answers to resolve conflicts that may arise between the individual patient’s rights and the social common good.

5 Comparison of Public Health Structures and Policies within Europe

5.1 Public Health Structures

Whilst most EU countries have comprehensive health policies which seek to prevent disease as well as develop health services, it does not necessarily mean that they have public health *systems*, such as an organised or connected group of agencies with a primary public health focus. In addition, methods of improving the health of the population depend upon a number of interrelated factors. These include: time; place; government style and political direction; degree of authority vested in, and exerted by, the state.⁹ Public health practice also varies according to the disciplinary base which may be narrow, predominantly focused on a medical model, or may be broader including a wider range of disciplines including political sciences.⁹ Public health practice also varies in response to new and urgent health priorities and changing governments and government bodies.

There is variation in terms of which organisations provide public health activities, and countries vary in the degree to which activities are centrally led or devolved more locally. These all depend on the historical evolution of public health and the past and present political direction of the country.

Public health as a label is not applied to exactly the same kinds of activities in different EU Member States. Public health activities in one country might be considered as a branch of medicine, while elsewhere such activities are considered to be a branch of social policy, public policy, environmental health, school health or preventive medicine.

Luxembourg is an example of this; there is no formally organised public health system, public health medicine is not a discipline, and there are no public health academic departments. However, a range of public health activities occur, provided by a mixture of non-governmental and governmental organisations, including: antenatal screening; immunisations; cancer screening; surveillance of school age children and provision of health education in primary and secondary schools; monitoring of environmental standards; national drug policy and monitoring of biological and chemical hazards and information dissemination.⁹⁸

Even within countries which recognise public health as a specialist occupation (either as a medical discipline or as a related profession), there is wide variation in the degree of organisation of training and accreditation. In France, the National School of Public Health was founded in the 1940s⁹⁹, but it remains an underdeveloped and unattractive medical specialty.¹⁰⁰ In Spain, specialist medical training in public health has only developed over the last 20 years, but uptake has been very slow.¹⁰¹ Similarly, in Portugal, the healthcare system has found it hard to recruit public health doctors, due to their low status, so general practitioners often have to take on responsibilities public health.¹⁰² This is also the case in Greece, despite public health being well organised in each of the regions.¹⁰³ In the UK there is a long history of public health medicine and a Faculty of Public Health which has responsibility for the training and accreditation of public health specialists. This has recently included non-medical public health specialists.¹⁰⁴

In countries where either health insurance funds or national health services are largely responsible for *public health*, such interventions have often focused to a larger extent on biomedical interventions such as screening and surveillance, while health promotion and structural interventions to reduce social inequalities have been given lower priority. This was the case in the UK, where public health services are organised through the National Health Service.¹⁰⁵ In corporatist countries, public health services may be split between the responsibility of the insurance funds for healthcare and the responsibility of the state for public health. In Germany, a shift in responsibilities for many health promotion and prevention services from public health services to the insurance funds has occurred and public health services have become much smaller and even less visible.¹⁰⁶ In Austria, public health services occur as preventive medical services focussed on surveillance, screening and immunisation.¹⁰⁷ Health promotion/ education activities have only recently been considered a part of public health services in Poland.¹⁰⁸

Because health policy in Belgium is devolved to the Communities (Flemish speaking in the north and French speaking in the south), public health services are not homogenous across the country. Few health policies are enacted at the national level, for example taxation policy on alcohol and tobacco and the compulsory polio vaccination programme.¹⁰⁹ In the Flemish community, the system is highly devolved to local practitioners who implement evidence-based interventions to meet nationally set targets.¹⁰⁹ In the French community the influence of the WHO came much later than to the Flemish community and their health policy has more emphasis on monitoring, surveillance and screening rather than addressing structural issues.¹⁰⁹ This situation is very similar to that in Spain where the underlying values for public health strategies vary from region to region, for example in Catalonia the focus is on interventions at the individual level, whereas in Valencia there is a much broader approach to public health.¹¹⁰

In the Netherlands, *public health* occurs in addition to the healthcare system, involving many different agencies at both the local and national level. It has a broad remit and is decentralised.¹¹¹ Similarly, in Sweden, despite successes in programmes targeting specific diseases, the focus of public health at a local level is changing to address structural determinants of health.¹¹² This is also the case in Finland too, where many initiatives are conducted at the community level and structures are targeted for change as much as individuals.¹¹³

However, the difficulties involved in targeting structural and not biomedical influences are acknowledged in Denmark. A combination of limited resources and lack of coordination due to the degree of decentralisation of health services, coupled with a traditional orientation to curative not preventive activities has made addressing structural influences on health difficult.¹¹⁴

All of the countries with corporatist social health insurance financed healthcare systems, apart from Luxembourg, currently have highly devolved public health services. For example, population health services in Germany are organised on a local level, and interventions are not necessarily co-ordinated between regions, despite the establishing of the German Forum for Prevention and Health Promotion in July 2002 at the federal level. Surveillance procedures for communicable disease control were only standardised in 2000.¹⁰⁶ A broad range of organisations are responsible for different aspects of preventive work which are both state and non-state, for example, under the Ministry of Health there is the Federal Office for Health Education in Cologne and a Central Association for Health in Bonn-Bad Godesberg, but there is also the German Centre of Public Health Care in Frankfurt, which is an

association of non-government organisations (NGOs) which are active in the field of prevention and health promotion.¹¹⁵

It would seem harder to co-ordinate public health interventions in a corporatist healthcare system because, by its very nature, it is not centralised. This is the case in Germany where public health decision making is devolved to the Länder level but national health policy must be reached by consensus by all Länder levels.¹¹⁶ For interventions such as cancer-screening, decentralisation may be viewed as a serious problem within the system.¹¹⁷ However, devolution to the local level can also be seen as a positive strategy for facilitating community empowerment and multiagency working for health. Consequently, although decentralisation is a relatively new feature of public health services in the Netherlands, the shift was viewed as a necessary one in order to facilitate community involvement. Some programmes have remained centralised – notably the National Vaccination Programme, and certain national screening programmes.¹¹¹

However, public health services in the social democratic countries are not necessarily characterised by centralisation. In the social democratic states of Southern Europe (Spain, Greece, Portugal and Italy), health and welfare services are devolved to the regional or even local level. However there has also been a *domino effect* in both Italy and Spain where policy innovation in one region has led to neighbouring regions implementing similar changes, including some policy changes at national level.¹¹⁸

Public health services are also devolved and organised at the municipal level in Sweden and Denmark, with research and training being the concern of national level structures.¹¹² By contrast, the UK is extremely centralised and hierarchical – local Health Authorities have a responsibility for pursuing population based, public health strategies within a framework set out by the national Department of Health.¹⁰⁵ The Polish sanitary-epidemiological system is similarly centralised and hierarchical.¹⁰⁸

5.2 Communicable Disease Control

The need to be sympathetic to the suffering of an individual patient may have to be tempered by a need to prevent spread of a disease to others. Thus the normal protections to privacy and civil liberties within health care may be compromised in the public interest. For example, in many countries informed consent is not required for passing on information about notifiable diseases to public health authorities. However, even in this context, confidentiality still needs to be protected as far as possible to give reassurance to patients concerned about stigmatising diseases such as HIV and other sexually transmitted diseases. Without some reassurances of privacy, potentially infective individuals may not come forward for testing and treatment. Control measures for gastrointestinal infections may require that affected food handlers are compulsorily excluded from work in the public interest. However, compensation measures are important to discourage people from hiding their illness through fear of the economic consequences. If persons (suspected to be) suffering from a communicable disease refuse to co-operate, they may be subject to involuntary detention, isolation, quarantine, testing, medical examination and, at the extreme, involuntary treatment.

5.2.1 Involuntary detention, isolation and quarantine

Individuals (suspected to be) suffering from particular communicable diseases may be subject to involuntary detention, isolation and quarantine in all of the countries examined: Austria, Belgium, Denmark, Finland, Germany, Ireland, Italy, the Netherlands, Poland, Sweden and the UK. In Poland, all residents and any sick persons arriving from abroad may be subject to compulsory hospitalisation, isolation and quarantine where they are suspected of having particular infectious diseases. Contact cases are also subject to restriction on their movement. Inter-country variations exist in relation to the amount of time persons may be involuntarily detained, whether or not a court order is necessary for such detention to occur, and the extent of any punishments for failure to cooperate.

5.2.2 Employment restrictions

Persons with communicable diseases can be prohibited from attending work in Austria, Denmark, Finland, Germany, Ireland, Poland, Spain and the UK. Regulation tends to be stronger for those working in the food industry (Austria, Denmark, Finland), and for those working with vulnerable groups including children, the elderly, and individuals who are hospitalised (Finland, Germany, Poland). In Austria, Finland, Germany, Ireland and the UK, persons who are isolated or prohibited from attending work can be financially compensated. Such compensation may take the form of a daily allowance (Finland) or may equate to sickness pay (Germany) or reimbursement for loss of income (Austria, Finland). Employers may also be entitled to compensation during their employees' period of absence (Finland, Ireland). However, as an incentive for persons to accept voluntary measures, those who have been forcibly isolated may not be entitled to such financial compensation.

5.2.3 Restrictions on children

Children and young persons (suspected to be) suffering from a communicable disease may also face restrictions. They may be ordered to be absent from school or any other educational institution for a prescribed period (Finland, Poland, UK), and, in the UK, all children below a certain age may be excluded from, or refused admission to, a place of entertainment or assembly, for example cinemas, arcades, sports grounds or public halls. Parents and venue managers who fail to enforce the regulations may be subject to conviction and a small fine.

5.2.4 Involuntary Testing and Medical Examinations

Medical tests and examinations may be conducted on individuals without their consent in Denmark, Germany, Finland, Italy, the Netherlands, Poland, Sweden and the UK. Such measures may be restricted to those cases where there is an immediate danger for others (Denmark, Netherlands). In Germany, while involuntary diagnostic examinations including the taking of blood and other specimens is permissible, further invasive examinations and any examination requiring anaesthesia cannot be performed without the consent of the patient. In some countries involuntary testing and examination may be extended to the *well* contacts of people with a communicable disease (Finland, UK), those who live or work in specific places (Finland), or suspected carriers of communicable disease entering the country (Poland). By contrast, only people suffering from tuberculosis (TB) can be subjected to involuntary testing in Austria. There, failure to comply with the ordered examinations may be punishable by a small fine or temporary imprisonment.

5.2.5 Involuntary treatment

Individuals can be involuntarily treated in Austria (only against TB), Belgium, Denmark, Finland, Ireland (although the legislation is vague), Italy and Poland. Perhaps the most extreme example of involuntary treatment can be found in Poland. In contrast to countries such as Denmark and Finland, where only patients with more dangerous infectious diseases can be subject to involuntary treatment, in Poland any resident may face obligatory treatment in a bid to prevent and contain all communicable diseases. Further, non-Polish citizens or residents who are infected or who are suspected carriers of communicable diseases may face mandatory testing, hospitalisation and treatment as they enter Poland. Finally, *at risk* sections of the population may face compulsory immunisation in Finland (where involuntary treatment is permissible) and in Germany (where it is not).

5.2.6 Other involuntary measures

Irrespective of the legal situation regarding involuntary treatment, other measures may be carried out without the patients' consent. For example, in Belgium, Denmark and Poland (where involuntary treatment is permissible) and in Germany, Sweden and the UK (where involuntary treatment is not permissible) measures such as the disinfection of living spaces, the disinfestation, treatment or extermination of insects or animals and the destruction of property may be undertaken without the consent of the patients.

5.2.7 Compatibility with human rights legislation

Such freedom-limiting interventions may infringe upon an individual's bodily integrity, civil liberties and human rights. However, although international legislation, such as the Council of Europe's Convention for the Protection of Human Rights and Fundamental Freedoms, assert one's "*right to liberty and security of person*" (Art. 5) and "*to freedom of association with others*" (Art. 11), caveats permit such rights to be contravened where justified in the interests of public health or to prevent the spread of infectious disease.

5.3 Drug Policy

Fighting drug related problems and drug addiction are major public health challenges. While society may wish to discourage drug use, it is having to face the reality that drug use is probably a permanent feature of 21st century European societies. Many people are able to combine occasional drug use with their other family, economic and social commitments. Other drug users however, experience serious morbidity and mortality as a consequence, with associated implications for family members and crime etc. While health education messages about the risks of drug use should continue, campaigns advocating abstinence have been replaced by more pragmatic approaches encouraging users to manage risk. For critics, such messages appear to condone use of illegal drugs. However, it is impossible to hold to a line of the danger of drugs when governments permit the use of legal drugs such as alcohol and tobacco which can be just as addictive, harmful to health and destructive to family life and societal networks. Thus policies to decriminalise the use of *softer* drugs such as cannabis, attempt to distinguish their use from *harder* drugs such as heroin, even though there are still public health dangers of the former, in an attempt to make public health messages about the latter more credible. Similarly, a consequential approach is used to justify the establishment of needle exchange programmes, recognising that some people will use intravenous drugs, and so they may as well be supplied with sterile needles and equipment to reduce the transmission of blood borne infections such as HIV and hepatitis.

5.3.1 Cannabis

There is no country in Europe where cannabis is actually a *legal* drug.¹¹⁹ In most European countries, drugs laws pertain to possession, supply, import etc. — rather than to drug use itself. In Finland, France, Luxembourg, Greece, Sweden and Spain drug use is illegal, although the criminal status of drug use has consistently been the subject of much heated debate in France.¹²⁰ In Portugal, all drug use ceased to be a criminal offence in July 2001. In Spain, Italy and Portugal,¹²⁰ and recently in Luxembourg and Belgium (in 2001 and May 2003 respectively), cannabis possession for personal use is treated as an administrative rather than criminal offence in most cases. Similarly first offences of possession are typically treated as an administrative rather than criminal offence in Ireland.¹²⁰ Possession for personal use has been criminalised in Poland recently and in Denmark offenders are generally prosecuted.¹²⁰ In most cases in Sweden, Greece, Germany and France, drug users receive a warning which may be accompanied by a request to contact a social or health service.¹²⁰ In Greece and Austria, users are put into treatment rather than prison.¹²⁰ In Finland, since 2001, prosecution can be waived if the suspect has sought treatment for addiction.¹²⁰

5.3.2 Classification

In Austria, the UK, Finland, Ireland, Italy and the Netherlands the legal sanction for drugs related offences depends on the relative harm of different drugs.¹¹⁹ Recent developments in drug policy in Belgium and Luxembourg and the UK, (where cannabis was reclassified as a Class C drug with effect from 1 January 2004. Similarly in the Netherlands there is a distinction between *hard* (List I) and *soft* (List II) drugs, offences involving List I drugs would be more severely dealt with than those involving List II drugs.¹²⁰ In Germany the drug classification reflects their relative medical utility. This system classes cannabis, cocaine and heroin as Schedule I – non-marketable narcotics, Schedule II relates to unlicensed pharmaceuticals and Schedule III are marketable drugs available only on special prescription.

5.3.3 Harm reduction for injecting drug users

Harm minimisation/reduction interventions include needle and syringe programmes (NSP), outreach training in safer injecting practices and methadone maintenance programmes. Facilitating safer drug use through needle exchange and the distribution of other paraphernalia to injecting drug users is recognised as an extremely efficient and cost-effective way of preventing the spread of HIV and other blood-borne diseases.

5.3.4 Needle and Syringe Programmes (NSP)

The public health rationale of NSP is focused on the prevention of HIV/AIDS and other blood-borne viruses. Geographical coverage varies from one country to another. Needles and syringes may be *exchanged* at various facilities, in all countries except Sweden. Distribution through pharmacies and/or medical facilities takes place in Spain, Portugal, Denmark, France, Sweden, the Netherlands, Belgium and the UK. Peer distribution takes place in Belgium, Czech Republic and the UK. In Germany, Denmark, Spain, France, Italy, Luxembourg, Hungary, Austria and Norway there are also vending machines where materials may be safely disposed of. The only supervised consumption facilities currently are in Germany, the Netherlands and Spain.

5.3.5 Treatment programs

Drug-free treatment for opiate use predominates in Norway, Sweden, Finland, and Poland, while substitution treatment for opiate use predominates in Denmark, Germany, the Netherlands, Belgium, Luxembourg, France, Spain, the UK and Greece. There are differences over the main substitution drugs (buprenorphine; dihydrocodeine; Slow-release morphine; Heroin).¹¹⁹ Throughout Europe there are at least some legal provisions for alternative sentencing of problematic drug users convicted of non-violent drug related crimes. Some countries have specific provision for the *compulsory* detention and treatment of drug addicts as an alternative to a prison sentence (the Netherlands, Norway, Sweden, Poland). In Greece and France there is also legal provision for compulsory detoxification, but these are very rarely, if ever, used.¹¹⁹ In April 2002, Denmark dropped legal provisions allowing for the forced treatment of drug addicts, although these provisions had never been used.¹²¹ In Austria, the UK, the Netherlands and Ireland, policy proactively encourages drug users in the criminal justice system to access treatment services. In Sweden it is a requirement that those who enrol on a methadone substitution programme are not under arrest, sentenced to imprisonment or incarcerated. In Poland there is also provision in law for both compulsory (maximum of two years) and voluntary treatment instead of a prison sentence to adult offenders.

5.4 Genetic Testing in Employment

Regulations for Health and Safety in the workplace are important to insure that the interests of individual employees are not abused by employers in the drive for profit. However, employees also have obligations: to their employer, by ensuring that they are fit to do the job they are paid to do; and to other employees and members of the public. For example, employers must provide appropriate health and safety, fire and other protective equipment and the necessary training on how to use it. Employees must attend such training and use the equipment provided. Employees should not attend for work under the influence of alcohol or drugs, especially if their ability to use machinery, for example, is impaired such that they and third parties are put at risk as a consequence.

The genetic testing of (potential) employees may be used to: predict the future health of employees; indicate genetic susceptibility to conditions linked to the working environment (e.g. hazardous substances); test for previous exposure to potentially hazardous substances; and test for genetic disorders that could place the employee, fellow employees or the general public in danger. Each of these possibilities has implications for predicted levels of sickness absence, loss of productivity, sickness benefits, pension entitlements, and the costs associated with health insurance and compensation payments. Testing may also lead to genetic discrimination in the workplace. However, genetic testing ignores non-genetic factors related to disease, cannot predict when or how seriously a person may be affected, and obscures the needs of employees without genetic pre-dispositions for a safe working environment. The position of occupational health physicians is also problematic, as the usual obligation of doctor to their patient is potentially biased by other obligations that the doctor has to the organisation that employs them.

5.4.1 Countries with explicit regulation

In countries where genetic testing in employment is explicitly regulated employers may be prohibited from requesting genetic tests or obtaining the results (Austria), or they may only obtain such results if required by law (Denmark), if not prohibited by any other law (Ireland), if it is relevant to assess the employee's ability to perform the work tasks (Denmark, Finland, the Netherlands), in order to protect the health and safety of the individual or third parties (Denmark), or for medical purposes (France, Sweden).

5.4.2 Countries with no explicit regulation

Despite references to the protection of personal data, privacy and health information genetic testing in employment is not explicitly regulated in Belgium, Germany, Greece, Italy, Poland, Portugal, Spain or the UK. However, non-legally binding recommendations, memoranda and codes of practice do advocate the prohibition of genetic testing in employment (Germany), the restriction of genetic testing to issues of public safety or medical purposes (Germany), and prohibition of discrimination on the grounds of genetic test data (Germany, Italy, Spain). In Portugal, testing for pre-dispositions or exposure to hazardous substances could theoretically be justified in the interests of the employee's health and safety as long as such tests do not degenerate into broader genetic testing, genetic discrimination or a means to avoid improving safety conditions for all employees. In Spain, employers should be informed of those genetic test results relevant to an employee's ability to undertake the job or the necessity of improving protective and preventive measures. Finally, in the UK, employers may require employees to undergo genetic testing and may lawfully discriminate against individuals on the basis of their genetic test results. A draft Code of Practice recommends that genetic

testing is only valid where an employee may be at risk in a particular working environment or may pose a serious safety risk to others.

5.4.3 Health and safety and the protection of third parties

Irrespective of whether genetic testing in employment is explicitly regulated, the relevant legislation, guidelines and recommendations in many countries contain a caveat to the effect that genetic testing may occur if in the interests of the health and safety of the individual or third parties. Such exemptions apply in Belgium, Denmark, Finland, Portugal, Spain and the UK, and are recommended in Germany. Finland and the UK make explicit reference to employees engaged in *safety critical work*, such as transportation, the emergency services, signal workers, where issues of public safety arise. Such employees may theoretically be subject to genetic testing or refused employment if they fail to comply.

5.4.4 Punishments for the (mis)use of genetic test results in employment

Employers may face fines or temporary imprisonment (Finland, France, Sweden) if they do not comply with the regulations or if they (mis)use employees' test results

5.4.5 Prohibition of discrimination in employment on the grounds of disability

Despite the widespread inclusion of disability as a protected ground in anti-discrimination legislation in Europe, it is often unclear whether this extends to discrimination on the grounds of genetic predisposition or susceptibility to disease. Only French legislation makes explicit reference to genetic test results. The inclusion of genetic data is not explicit in anti-discrimination legislation in Germany, Greece, Ireland, or Poland, or within the anti-discrimination clauses of the national Constitutions in Portugal and Spain. The situation is less clear in Italy where the legislation implies protection for people with diseases or disabilities of a genetic origin, but not necessarily for those with genetic predispositions or susceptibilities to disease. In the UK, the Human Genetics Commission recommended that the Government introduce a new piece of legislation dealing specifically with genetic discrimination, but new legislation has not been forthcoming.

5.4.6 The wider European and international position:

The Council of Europe (1992, 1997) has asserted that genetic testing (in employment) should be voluntary and only undertaken for health purposes, scientific research, the direct protection of the person or third parties, or if lawfully required. The Council of Europe (1997) and European Union (2000) also seek to prohibit discrimination on the grounds of genetic *heritage* or *features*. The European Group on Ethics in Science and New Technologies (2003) concurred that any genetic testing in employment must be necessary for the protection of the health and safety of the employee or third parties, and that the principle of non-discrimination be upheld. At the international level, UNESCO (1997), the World Medical Association (1998) and the World Health Organisation (1999) have also recommended restricting genetic discrimination.

5.5 Immunisation strategies

Childhood immunisation against diseases such as measles, mumps and pertussis (whooping cough) is the single most effective public health mechanism in raising health quality in both the developed and the developing world. Immunisation protects the vaccinated individual from communicable disease, although the decline in incidence of infectious disease over the last 150 years has been largely achieved by other public health measures such as improved housing, nutrition and sanitation. The degree of protection will depend on the efficacy of the vaccine and on the receptiveness of the individual. While vaccines may provide incomplete protection which declines with time, the uptake of immunisation programmes is usually high. There have been numerous scares that have reduced the public trust and hence the uptake of vaccination. While the magnitude of the precise risk of side effects with vaccines is controversial, the chance of severe morbidity and mortality following an unimmunised individual becoming infected is significantly higher. The individual and public health would both therefore benefit by widespread take up of immunisation. There will be some individuals who are unable to be immunised because of contraindications. High vaccine uptake is particularly important to ensure herd immunity to break the chain of transmission within the community and hence protect those who have not been immunised because of a contra-indication. A rational individual acting only in self interest may choose not to be immunised and hence avoid the small risk of vaccine complications, while still receive indirect protection against the communicable disease through herd immunity because others have been willing to accept the risks to receive direct protection. However, if a substantial proportion of the population were to gamble in this way then herd immunity would not be achieved, and outbreaks of communicable disease would result. In order to avoid this, governments use varying degrees of compulsion and incentives to require/encourage parents to act in what the State thinks is in the best interest of the child. Similar incentive may be used to motivate health professionals to encourage such decisions.

Currently there is wide variation between EU member states concerning vaccination policy, and the European Centre for Disease Prevention and Control is advocating a harmonisation of vaccine strategies. The current strategies of different member states are based upon differing views of private and public interest.

5.5.1 Compulsory immunisation

In Belgium, Greece, Italy and Poland, immunisation against particular communicable diseases is compulsory. Punishment for non-compliance includes fines in Belgium, Italy and Poland, and potential imprisonment in Belgium. Currently, in Italy and Greece, parents are required to show their children's immunisation certificates upon enrolment in school, however they cannot be refused admission if they are not fully immunised.

5.5.2 Voluntary immunisation

In all EuroPHEN countries other than Belgium, Greece, Italy and Poland, immunisation is voluntary. This is based on a number of factors including a belief in parental choice, fears that compulsion could prove counter-productive, the Constitutional protection of private family life (Germany, Ireland), and trust in the State/public health authorities (Sweden, Finland).

5.5.3 Consent

Consent to treatment is necessary to respect the autonomy of the patient in health care. In countries where immunisation is compulsory, the State effectively over-rides the wishes of parents and parental consent may not be required. However, in countries where immunisation is voluntary, parental consent is sought for child immunisations. Consent may be verbal, written or implicit in taking one's child to a medical appointment. However, there is some ambiguity over consent for immunisations undertaken in non-clinical settings such as schools. In many countries, young people over the age of 16 may consent to or refuse immunisations. In some countries the child's consent is considered or required at younger ages (or levels of maturity): 14 in Austria; 12 in Denmark and the Netherlands. Under certain circumstances the State may intervene in parental decision-making, for example if parents disagree on whether to immunise (see the legal cases in the UK in 2003).

5.5.4 State incentives for parents

In countries where immunisation is voluntary the State may encourage parents to have their children immunised through the offer of incentives. Non-financial incentives include the potential to refuse school enrolment to unimmunised children (Italy, Greece), social pressure from the State/health authorities (Denmark, Italy, Sweden) or other parents/society, and consent refusal forms that require parents to make an active decision about their child's immunisation status (Ireland, Italy, the UK). Incentives may also be financial. For example, in countries where immunisation is compulsory parents may be fined if their children are not immunised (Belgium, Italy and Poland). Other financial incentives include payment to parents whose children complete the immunisation schedule (Austria), and the potential reduction in State benefits to parents whose children are not fully immunised (under discussion in Ireland). Finally, childhood immunisations are free in all countries, except Poland (where most immunisations are compulsory).

5.5.5 State incentives for health professionals

In most EU states incentives are in place for health professionals to increase immunisation take-up. Financial incentives include fee per consultation or service (Austria, Belgium, Denmark, Germany and Ireland), and bonus payments for reaching immunisation targets (UK and Ireland). Non-financial incentives include professional (peer) pressure, consent refusal forms (in parts of Ireland, Italy and the UK), monitoring of immunisation rates (Greece) and continuing professional evaluation (Spain).

5.6 Protection of Children and Vulnerable Adults in Clinical Research

The involvement of human beings in research is crucial in order to develop new medical interventions. As we benefit from the altruism of previous generations to contribute to research, arguably there is a moral obligation on us to also participate so that future cohorts of patients may be helped. However, research subjects should not be treated as means towards technological advancements. Various examples of abuse of people in research during the last century led to the introduction of ethics review procedures and other legal and regulatory protections. These safeguards are particularly important in the context of vulnerable groups such as children or people who lack mental capacity, and are unable to give informed consent in their own right. Certainly such individuals should not be expected to be enrolled in research, where adults with mental capacity could be approached and asked to be research subjects. But ruling out research on vulnerable groups completely would mean certain valuable categories of research could not be conducted, and as a result, for example, we could not assess the efficacy and safety of drugs in children or study the causes of mental incapacity. Thus particularly strict ethical scrutiny is required in these circumstances to ensure that vulnerable groups subjected to no or minimal harm, while still ensuring that beneficial research is permitted.

In 1947, the Nuremberg Code laid the foundation for guidance for research ethics principles and practices. The World Medical Association's Declaration of Helsinki (2000) and the International Conference on Harmonisation's Tripartite guidelines for good clinical practice (1996) and in the Council of Europe's additional draft Protocol to the Convention on Human Rights and Biomedicine (1997) concerning Biomedical Research (2004) followed on from this. The European Commission introduced a legal requirement for the ethical review of all clinical trials involving medicines across Europe and specified criteria to be considered when protecting the interests of research participants.

5.6.1 Inclusion of Adults who lack capacity to consent

Any informed consent given or refused by the adult prior to the onset of incapacity should be considered and the consent or opinion of a proxy acting in the best interest of the individual should be sought. Austria, Belgium, Denmark, Germany, Greece, Italy, Spain and the Netherlands provide mechanisms by which proxy *consent* is provided on behalf of the individual. The UK makes a distinction between medicinal product clinical trials and other invasive research where the former requires *consent* but the latter requires an *opinion*. Finally, in Sweden, it is only the *opinion* of a representative which is sought. The proxy may be nominated by the individual prior to the loss of capacity; may fall *naturally* into the role; or may be appointed by a court. In Austria, Germany, Italy and Sweden there is a system of proxy that is determined by the courts – this is not necessarily required in Belgium, Denmark, Spain or the UK. In Belgium, Denmark, Germany, Italy, the Netherlands, Spain, Sweden and the UK a relative can take on the role of proxy.

Direct therapeutic benefit or benefit through an increase in knowledge to the individual or patient group should be a condition of participation in clinical research and involvement must directly relate to their condition as long as the risk to the individual is negligible as stated in the Convention for the Protection of Human Rights and Dignity of the Human Being (Council of Europe Art 17 (2) (i)). This Convention has been signed and ratified in Denmark, Greece, Ireland and Spain and thus provides a basis for policy. Seven further countries have signed

but not yet ratified the Convention (Finland, France, Italy, Luxembourg, Netherlands, Poland and Sweden. It remains unsigned by Austria, Belgium, Germany and the UK). Research on adults lacking capacity with no direct benefit is also permitted in Austria, Germany (under certain circumstances), the Netherlands, Sweden and the UK.

5.6.2 Inclusion of Minors in Research

The age at which a minor has the capacity to understand and form an opinion on the information relating to a trial and the age at which the opinion of the minor should be respected and complied with in addition to, or over and above, the wishes of the parents, varies throughout Europe. Where children are involved in research, it is a common condition across partner countries that there should be a direct benefit to the child and/or group and relate to a clinical condition of the child and/or group of that child. Alternatively, that the research, by its nature, can only be carried out in that specific population for the benefit of that population. Where there is no anticipated direct benefit there should be minimal risk. It seems that all countries, with the reported exception of Italy and Ireland with respect to neonates permit research which is of no direct benefit to the child under the condition that there is minimal risk.

5.6.3 Inclusion of Women in Research

The need for extra protection for women of child-bearing age and the potential risks of exposing a developing foetus have been recognised. From the data collated, it appears that there are four positions taken by countries. Firstly, a country may have no specific policy on inclusion/additional protection as in Belgium, Denmark, Finland, Greece, Ireland, Italy, the Netherlands and Sweden. Secondly, Austria and Spain have policy on additional protection but not on inclusion as is the case. Thirdly, UK has a formal policy on inclusion but no formal policy on additional protection. Fourthly, Germany has a formal policy on inclusion and additional protection.

5.6.4 Inducement to research

From the data received, inducement policies regarding adults with capacity are as follows. In Belgium, Finland, Greece, Italy and Sweden no profit is allowed. In Germany, the Netherlands and Denmark inconvenience is compensated in excess of travel expenses/loss of earnings. And there are partial or no formal restrictions on payment in Austria, Spain and the UK. Ireland would probably also fall into this latter category as there would appear to be no formal policy on financial inducements.

5.7 Smacking policy

Article 19 of the Convention on the Rights of the Child and its Treaty Body the Committee on the Rights of the Child, requires States to protect children from “*all forms of physical or mental violence*” while in the care of parents or others. This is interpreted as requiring States to protect children from all corporal punishment. Corporal punishment is in most countries a deeply embedded traditional practice and it is a deeply personal issue: most people were hit as children; most parents have hit their children. Research on the prevalence of corporal punishment in Europe suggests that it remains high in many countries except those where it has been against the law for several years. A wide range of literature suggests that professional opinion is divided on the use of smacking as a form of discipline of young children. Some believe that smacking is an important component of discipline. Others believe that smacking is at best ineffective and at worse leads to an escalation of unwanted behaviour or abuse.

5.7.1 Smacking in schools

In Austria, Denmark, Finland, Germany, Greece, Ireland, Luxembourg, Netherlands, Portugal, Spain, Sweden and the UK corporal punishment in schools is expressly forbidden. In Poland, corporal punishment in schools is forbidden by the Educational System Act which provides a general requirement to respect the personal dignity of students. There is not a special law that regulates students’ rights or specifically forbids corporal punishment at school, so more general legal acts have to be invoked. In Italy corporal punishment has been unlawful in schools since 1928 and abuse of children is forbidden, however, smacking, slapping and similar punishments are not explicitly forbidden by law at school although teachers prone to this behaviour usually are told off by Educational Authorities. In Belgium, a narrow interpretation of the law states that it is forbidden to beat children although there is no explicit reference to the school situation. In France there is no explicit prohibition in law of corporal punishment in schools and *light correction* is tolerated.

5.7.2 Smacking in the home

In Denmark, Finland, Germany and Sweden smacking in the home is forbidden. In Austria, Italy, Luxembourg, Portugal, Poland and Spain the act of smacking is not explicitly named in the law. In Poland, physical violence that causes non-accidental injuries (fractures, bruising etc.) against children in the home is forbidden. However, slapping, patting etc., or actions that do not cause injuries are treated as a traditional part of upbringing, and are perceived as the so-called permissible reproach. In Belgium, there is no law explicit for smacking of children in the home and corporal punishment by parents is tolerated in society. In Greece, parents have a right to take *corrective measures*, although according to article 1518 of the Civil Code (1983) “*only if these are necessary from a pedagogic point of view and do not affect the child’s dignity*”. In France, corporal punishment is lawful under the parental *right of correction*. In Ireland and the UK the law provides defences for those who use corporal punishment to discipline children allowing *reasonable chastisement* or *lawful correction*. In Netherlands there is no defence in legislation for the use of corporal punishment by parents, but it is commonly assumed that parents have this right.

5.8 Anti-Smoking Policies

The European Union has sought to harmonise anti-smoking policies by setting directives which are implemented through national legislation. There are a variety of measures which are used to decrease smoking including: increasing taxation; regulating advertisements of tobacco products; regulating tobacco packaging and products; restricting areas where people are able to smoke and increasing information and health campaigns on the dangers of smoking. The regulation of licit drugs, such as tobacco and alcohol, requires governments to balance the rights of the individual to make their own choices in their own private sphere and the interests of the public good.

5.8.1 Taxation

According to the World Bank a price rise of 10% decreases consumption by about 4% in high-income countries.¹²² As a result in 1992 the EU sought to define the structures of taxation within Europe and to a certain degree *harmonise* taxation of tobacco. The three directives on taxation of tobacco¹²³ products placed taxes on cigarettes at a minimum of 70% of the final retail price (minimum rates of 57% for excise taxes and 13.04% for VAT). These directives are currently under review. Mediterranean states have a percentage tax system which exaggerates the price difference between cheap and expensive brands. This allows some brands to remain low priced compared to Northern countries where the *flat rate tax structure* means there is little difference between brand prices.¹²⁴ Higher taxes on licit drugs such as tobacco may encourage smuggling, black markets and criminality. This is of higher concern for EU states which are neighbours to countries with less control over their borders and have lower taxation on tobacco goods.

5.8.2 Restricting advertising of tobacco products

In 2003 the EU brought the Tobacco Advertising Directive which took effect in July 2005. This EU directive applies to advertising and sponsorship in print media, on radio and over the Internet with a cross-border dimension. A number of areas fall outside of its scope, including local advertising i.e. in cinemas and on billboards as well as merchandising and local tobacco sponsorship where participants come from only one Member State. Of the 25 member states only Germany and Luxembourg had not passed the required law by the 1st April 2006 deadline. Luxembourg is currently in the process of doing so; however Germany may be taken to the European Court of Justice.¹²⁵ The tobacco industry has sought to overcome the restrictions on advertising by indirect advertisement; branding tobacco related products and *brand-stretch* e.g. Marlboro Classics range of clothing.

5.8.3 Restrictions on smoking in public places

European countries have various legalisations, most of which ban smoking in public places such as government buildings, schools, hospitals, and on public transport. There are no Europe-wide laws covering all workplaces, but rather two directives offer limited protection from second-hand smoke.^{126 127} Each member state must implement these directives in their own legalisation. The main argument which has been perused is that a worker has a right to a non-smoking work environment. Only Ireland has a full ban on smoking in all workplaces (2004). 14 other countries, including France, Germany, Italy and Spain have regulated smoking in public places (i.e. government buildings and transport) but made provisions for smoking in pubs and hospitality areas. The hospitality industry is self-regulated in Germany, the Netherlands and Austria. In Belgium and France separate smoking areas must be provided.

In Italy and Sweden smoking areas in public places must be in a separate ventilated smoking room. In France, Germany and the Netherlands workplaces have special rooms for smokers. In Greece, Poland, Finland and Spain there are various exemptions for the hospitality industry¹²⁸.

5.8.4 Health Information Campaigns

In May 2001, an EU directive came into force which regulated tobacco products.¹²⁹ The directive also increased the size of health warnings placed on cigarette packets from 4% to a minimum of 30% of the surface of the front of the packet and 40% of the back of the packet. The European Union itself also promotes non-smoking through campaigns and in 2005 launched *HELP – For a Life Without Tobacco*. The main aim of this campaign is to *denormalise* smoking within at risk groups (i.e. adolescents and young adults - 15 to 30 years olds).

5.8.5 Regulation of product

The 2001 EU directive regulating tobacco products¹³⁰ imposed upper limits on the tar (10mg), nicotine (1mg) and carbon monoxide (10mg) content of cigarettes. The European tobacco industry may also be affected by a new chemicals directive, REACH (Registration, Evaluation and Authorization of Chemicals). This framework requires the testing of many chemicals that are used in consumer products to establish their effects on health. The law is expected to be adopted by the end of 2006.¹³¹ The EU also supports the production of tobacco through the Common Agricultural Policy (CAP). In 2004 the Council of Agriculture Ministers agreed to de-couple subsidies from production starting in 2006 and to be completed by 2010. After 2010 half of the subsidy will fund wider rural development and the remainder will be paid to farmers in the form of a single farm payment that does not encourage tobacco production.¹³²

5.9 Urban Planning Procedures

It has long been recognised that there are important links between environment and health. Inequalities in health will be explained by genetics and lifestyle choices as well as by the physical and social environment in which we live. It will be important to attempt to remove or reduce threats to the public health although this does not mean that industrial activities are necessarily all bad, even where processes and outputs are potentially dangerous to health, as the economic contribution to the local economy can help reduce poverty. Public policy needs to be guided by equity and justice, and economic benefits to the local community must be proportionate to the risks to health. Similarly, on an individual basis, where private interest is outweighed by public interest e.g. where there is compulsory land purchase, compensation at the appropriate market rate is necessary. At all stages, public consultation is important, with rights to object to planning decisions. Public policy also needs to recognise that protection of the natural environment is also a social good and a moral obligation, and hence advancement of human interests should not be our only concern.

5.9.1 Strategic planning

The size and nature of a project influences at what level of government planning permission is refused/granted. In general, smaller projects are dealt with at the regional or sub-regional level and larger projects at the regional or national level. Strategic Development Plans (SDP) can strongly influence decisions on planning applications. In the UK all SDPs are discretionary and act more as statements of intent. Planning permission can be given or withheld irrespective of whether or not the project fits in the SDP. In Germany all planning

decisions made at the local or regional level must accord with SDPs concerning ecological issues and these are made at the regional level. Countries such as Denmark use a zonal system, where there are various land-use categories and any plan must fit into these zones. It is the same in Poland but the plans on a local level are not obligatory so only 14 % of the land in Poland is covered by local development plans (LDP). In Ireland LDPs are changed every 6 years and must fit in with the National development plan. Public participation in drawing up the plan is encouraged and draft copies of the plan are given to various statutory and voluntary bodies to give specialist advice.

5.9.2 Consultation

In some countries, consultation is very limited. In Italy, consultation tends to be with various organisations rather than directly with members of the public. Consultation is only required in Greece in planning applications requiring an Environmental Impact Assessment. In the UK consultation tends to be passive, the public have to find advertisements on planning proposals in newspapers or on posters at the proposed site. Those with objections then have to initiate complaint. This leads to a planning system that is heavily weighted in favour of the developer. In other countries, consultation is proactive with letters being delivered to the homes of those directly affected, public surveys, presentations/ hearings and direct involvement of NGOs (Austria, Sweden, Belgium, Germany). Such more proactive planning systems mean that the voice of the public is taken far more into consideration.

5.9.3 Appeals Procedures

The type of consultation procedure in each country has an effect on the appeals procedure. Those with a comprehensive planning procedure aimed at getting the decision right the first time round have little need for a comprehensive appeals procedure (Austria, Denmark, Germany, Netherlands). The inclusive consultation process in Belgium, together with many levels of appeal (albeit time limited), mean that developers are very receptive to address the concerns of the public, so reducing the need for appeal. Whereas those countries with a more perfunctory planning procedure have much more comprehensive appeals procedure as a safety net against disadvantageous planning decisions (UK, Greece).

5.9.4 Compensation

Countries with better consultation processes, also place less emphasis on their compensation provisions. In some countries (Austria, UK, Poland, Italy) there is no explicit right for compensation for third parties, except in the case of government infrastructure projects where there may be compulsory compensation or purchase. In any other circumstance compensation must be pursued through the courts where success is unlikely unless negligence on the part of the developers can be proved. In other countries (Denmark, Belgium) compensation is available to those directly affected by the development, or in some cases (Greece), any group is eligible where a development has had an unfavourable effect. In Germany, compensation is available where protection of the public from negative effects of the project is not possible. In Ireland both developer and the public can claim compensation from the planning board if a decision reduces the value of an asset.

5.9.5 The Precautionary Principle

In Austria, Belgium, Germany, Greece, Italy, Spain and the UK, the precautionary principle is explicitly meant to guide the planning process. In Denmark and the Netherlands it has never been officially adopted into legislation, although both have signed up to international conventions that incorporate the principle. It is also part of Dutch and Swedish environmental policy. However all EU countries are bound by the EU directives that incorporate the

principle. One of the key EU directives that incorporates the precautionary principle is 85/33/EEC (amended 97/11/EC) which assesses the impact of large private and public projects on the environment. The implementation of this directive varies widely between countries, but it is mandatory throughout the EU.

5.10 The artificial fluoridation of public water supplies

Fluoridation, the process of increasing trace levels of fluoride in water supplies to an optimum level, usually of one part per million (1ppm), is a contentious public health issue. Intended to be a preventive measure against dental caries (tooth decay), particularly among children, the issue raises ethical questions and practical concerns about the potential harmful effects of consuming excessive amounts of fluoride.

Surprisingly the evidence on the efficacy and safety of Water Fluoridation is not conclusive. Lobby groups that oppose water fluoridation have made various claims about the safety of water fluoridation, although the only disease where there is significant evidence for an adverse effect is fluorosis. The evidence that artificially adding fluoride to the water supply should be an effective way of reducing dental caries, especially among socially disadvantaged children, is stronger. However, despite the fact that water fluoridation is *probably* effective and *probably* safe, very few countries in Europe have legislation that permit artificial fluoridation of water. Of those that do, actual fluoridation may be limited to certain regions. Some other countries have previously permitted water fluoridation, but have reversed the policy. Why then has a relatively cost effective public health policy not been more widely adopted? The extensive use of fluoride toothpastes has meant that population health across Europe has been generally improving over recent years, although health inequalities exist. The anti-fluoridation lobby have been very vocal and politicians have been reluctant to challenge their arguments. While the majority of claims of side-effects from water fluoridation have been disproved, the public seem unwilling to bear the small risk of morbidity and the aesthetic effects of fluorosis. The public no longer seem receptive to requests for accepting risks (even if theoretical and/or small) so that vulnerable groups such as children may benefit. Instead, the precautionary principle seems to be increasingly prevalent within Europe with public and politicians alike preferring not to take on any risk within public health policy.

5.10.1 Countries where fluoridation is currently permitted

Water fluoridation is currently permitted in Greece, Ireland, Spain and the UK, however the extent of such fluoridation varies. For example, while approximately 70% of the population in Ireland drink fluoridated water, this figure falls to just 10% in Spain and the UK. Although Greece has been able to fluoridate its water since 1974, concerns over the technical, administrative and financial complexities and over health and safety issues has meant that the law has never been implemented. The UK is the only country which requires local populations to be consulted prior to fluoridation occurring.

5.10.2 Countries where fluoridation was previously permitted

Finland, the Netherlands and Poland have experimented with fluoridation and ultimately decided not to fluoridate their water supplies. Reasons for ceasing fluoridation programmes include debates around efficacy (Finland, Poland), and concerns around mass-medication and the infringement of civil liberties (the Netherlands, Poland).

5.10.3 Opposition to fluoridation

The issue of artificial fluoridation does not arise in countries where water supplies are naturally high in fluoride (Denmark, Italy). In other countries, water supplies may not be fluoridated where alternatives are preferred (Denmark, Finland, Germany, Greece, Ireland,

Italy, the Netherlands, Poland, Sweden); where there are ethical concerns over fluoridating water supplies (Germany, the Netherlands, Sweden); or where there are concerns over the safety of fluoridation (Austria, Belgium, Germany, Sweden). Opponents of artificial fluoridation question the scientific evidence upon which claims of benefits from fluoridation are based. Much of the evidence is of *poor* quality and concerns over associated increases in dental fluorosis are not discounted. Fears of links between fluoridation and a range of more serious conditions and diseases are unproven and remain contested. Even where trace fluoride levels of 1ppm are considered safe, concerns remain over the potential effects of cumulative fluoride consumption.

5.10.4 Alternatives to the artificial fluoridation of public water supplies

Fluoridation has also been critiqued for treating the symptoms rather than tackling the causes of poor oral hygiene and dental caries in children. Thus, in countries that focus upon improving education, diet, and access to dental health services, artificial fluoridation may not even be a consideration. Alternatives to fluoridation provide individuals with choice over what they consume. This helps to define the individual as *best judge* and does not encroach on civil liberties or *bodily integrity*. Alternative measures include better dental health education in schools (Austria, Finland, Ireland, the Netherlands, Poland); the provision of fluoridated gels, pastes, tablets and rinses (Denmark, Greece, Ireland, Italy, Poland, Sweden); fluoridated salt (Germany, Greece); and bottled water high in fluoride (Italy).

6 Commentary on Comparison of Public Health Structures and Policies

The overall aim of EuroPHEN was to develop a normative framework of ethics for use within public health policy at a European level and within Member States. Normative frameworks should be derived from a moral understanding of how public health professionals should behave and how policy should be developed and implemented, rather than derived from current practice. This strand of EuroPHEN examining similarities and differences between public health structures, is useful therefore in examining how Member States currently balance private versus public interest, and provide an indication as to the possible acceptability of various ethical approaches to deriving a normative framework. However, the normative framework itself must be based on other moral considerations.

There is considerable variation between EuroPHEN countries in terms of the funding and organisation of health services and public health, for a combination of historical and political reasons. In some countries, public health is a branch of medicine, in others it does not exist as a medical specialty, in others it is a multi-disciplinary specialty, and in yet others it is not recognised as a profession in its own right. These factors also impact on the breadth of public health practice, ranging from biomedical interventions to policies to address inequalities. There is also a wide variation within and between the countries examined in terms of the various public policies examined.

It may be tempting to argue that a Member State places more relative value on public over private interest compared with another country, if it has a stronger Public Health regulatory framework. Similarly, pointing to specific policies which restrict civil liberties should not necessarily be taken as conclusive evidence about value placed on collective benefit.

The EU has sought to legislate in a number of these areas of public policy in order to bring a degree of uniformity of approach in Member States. These include tobacco legislation, protection of research subjects, use of genetic testing in employment, and urban planning issues. Although countries vary in the degree to which they have adopted these in theory and practice. These variations may be due to:

- the relative importance of an issue as a public health problem within each Member State;
- historical trends in the epidemiology of a disease or behavioural patterns.
- previous policy direction;
- the date of accession to the EU;
- the ability to update and amend legislation in the face of scientific developments and the rise of new issues requiring legislation;
- the resources to support such policy changes;
- the degree of politicisation of an issue;
- concerns from Member States to ensure maximum protection or accordance with existing laws and policies prior to adoption rather than a disagreement with the regulation per se.

Thus, for example, a Member State with a strict regulatory and enforcement framework may be expected to have a higher prevalence of a disease or its risk factors, or when the trend is worsening, compared to a country where a disease or risky behaviour is rare, or the trend

seems to be improving without the need to be intrusive on private lives and autonomous decision making. Exploring underlying epidemiology as an explanation for differences between countries was not within the remit of EuroPHEN.

During the work of EuroPHEN, historical events were noted that may also explain differences between policies in Member States, and between attitudes of citizens in different countries. However, once again, a detailed analysis of these was not part of the remit of EuroPHEN. The impact of historical events on public policy is illustrated by two examples, public policies to control dangerous dogs and gun control.

In the UK, The Dangerous Dogs Act 1991 (c. 65) was a policy response to rise in the newspaper coverage of attacks by American Pit Bull Terriers, particularly towards young children. This policy outlawed owning and breeding of four dog types which were seen as particularly aggressive; the Pit Bull Terrier, the Japanese tosa, the Dogo Argentino and the Fila Brasileiro¹³³. In 1997 it was amended following lobbying by the Dog's trust (then known as NCDL) to allow owners to register dogs which exhibited behaviour and physicality similar to the four breeds¹³⁴.

Gun control policy in the UK was initiated in response to Michael Ryan's actions which later became known as the Hungerford Massacre in 1987. In response the Conservative Home Secretary Douglas Hurd banned semi-automatic weapons (Firearms (Amendment) Act 1988)¹³⁵. In 1996 Thomas Hamilton killed 16 school children and one adult at Dunblane Primary School which led to the government setting up public inquiry and the Parliamentary Home Affairs Committee to begin its own investigation into Handgun Ownership¹³⁶. The public inquiry recommended some changes about licensing and using handguns, but didn't recommend a ban. However two petitions were started, one of which was led by the Scottish Mail, to ban all handguns. In February 1997 the government passed the Firearms (Amendment) (No. 2) Act 1997 which restricted ownership, however with a Labour win in May 1997 there was a further amendment which means that handguns have been almost completely banned for private ownership¹³⁶.

Thus public policies respond to historical events as well as being directed by public concern and demands for action. Sometimes, such incidents can have a cumulative effect on policy frameworks and perhaps of even greater influence on attitudes of citizens. Thus, for example, media reports of various *public health* concerns or scandals, even if subsequently demonstrated to be unfounded, have had widespread impact on public trust in politicians and public health officials, and hence willingness to accept restrictions on collective measures advocated by governments and agencies.

With these caveats, this chapter draws some conclusions about differences in moral value placed on private and public interest in the Member States studies.

Most countries are paternalistic with regards to smoking and communicable disease control, and the general trend is to increase the degree of paternalism with regards these two areas of policy. With regard to smoking, the EU has led the way for increasing state control over smoking in public places, advertisement, sponsorship, and health warnings on packaging, and all countries have followed this guidance although Germany is slower than others, due to influential tobacco lobbyists and an emphasis on personal freedom in lifestyles. With regard to communicable disease control, the increased profile of this area of public health following real or threatened international outbreaks and incidents (the rise of TB, SARS, avian and

pandemic flu, bioterrorism) has led to the development of new legislation in some countries which increase the state's power to contain and control, within limits.

All countries except France and Belgium have laws prohibiting the corporal punishment of children in academic institutional settings and are thus paternalistic within state run facilities in order to protect children. However, generally, corporal punishment is not prohibited within the home in the majority of European Member States. The exceptions are the Scandinavian countries of Finland, Sweden and Denmark have banned smacking in the home, as have Germany and Austria.

The Scandinavian countries, together with Poland, also tend to be more paternalistic within drugs policy compared to other western European countries. However many of the previously more liberal countries are now moving towards a more paternalistic goal of abstention rather than harm reduction, perhaps as a consequence of a previously more liberal approach which is perceived to have failed.

Immunisation policy is perhaps surprisingly more liberal in Scandinavia but this may be due to a historical high level of trust in the authorities thereby requiring less legislation to ensure adequate levels of vaccination coverage.

There are explicit laws to regulate genetic testing in employment and prohibit discrimination in many Member States. Although in many countries there are exemptions from the protection of individual rights if testing would protect self and/or others. Most countries are non-specific with regards to discrimination on the grounds of genetic tests. Because of the complexity of this issue and the continuous advances of this branch of science, these issues are under review in many countries and most seek to protect the individual worker. The overall direction is to be more paternalistic in terms of laws and punishments for non-compliance in order to protect the individual's rights, with exemptions in certain situations, in keeping with EU regulations.

There is increasing protection of children and vulnerable adults in clinical research across most countries in order to protect the individual rather than undertake research for the public good in line with EU Directives and the Declaration of Helsinki. There is variation in the degree to which these are implemented and worded and questions remain as to whether they provide the level of protection envisaged in practice. Austria, Spain, the UK and Ireland have only partial or no formal restrictions on payments to adults with capacity, a more liberal approach than the other countries which restrict this. Austria, Germany, Italy and Sweden require the appointment of a proxy for the purposes of consent in incapacitated adults to be made through the courts, in other countries it is more liberal. Germany has the greatest restriction on research in children, and also has the greatest protection for women in research. This more paternalistic approach to protect the individual may be related to historical factors relating to the Nazi era.

Understanding how historical events and underlying moral values have shaped contemporary public policy is important to the development of international public health policy. Although all EU countries are subject to various Directives, these are translated into practice in different ways and to different degrees depending on the *fit* with existing policies and practices. The Scandinavian countries have a stronger history of paternalism with regards public policy and this is evident in the sections above. Childhood immunisation is a notable exception, although this may be due to a strong historical trust in authority as noted above which has not

necessitated state intervention. Another notable exception is Germany which has public policy which differs from the European norm in two main areas, that of tobacco control where it is more liberal, and that of the protection of research subjects where it is more paternalistic. It has been speculated that this may be related to activities of the Nazi era, with contemporary governments keen to not repeat events of the past. However, in addition to historical reasons, the situation in Germany (and indeed other countries) may reflect to a large degree the influence of the tobacco industry. Thus despite a gradual change in German public opinion, political resistance remains quite high. Poland stands out in a number of areas of public policy as being more paternalistic than some other countries, in particular immunisation, communicable disease control, and drugs policy, these may be related to its communist past. Ireland generally is congruous with other member states except in the field of water fluoridation where it is the most paternalistic of all countries as the only country to mandatory fluoridate water supplies. Southern and Western European countries are generally more liberal, for example in terms of drugs policy, although France and Belgium are unusual in not banning corporal punishment in educational settings to protect children.

In summary, with the caveats noted at the start of this chapter, some countries tend to adopt relatively consistent patterns of the degree of liberalism versus paternalism whatever the public health issue studied (for example, Scandinavian countries tend to be more paternalistic, Western and southern European are more liberal). In addition, there is a degree of consistency between which public health policies are more liberal versus paternalistic depending on the issue, irrespective of the individual country (tobacco control and communicable disease control tend to have more paternalistic policies).

7 Attitudes of European Citizens to Public Health Policies

As with the comparison of structures and policies within Member States, any empirical data on the attitudes of European Citizens, should not be used to develop a normative ethical framework for public health policy. However, this strand of EuroPHEN, examining citizen attitudes, provides an indication of the acceptability of restrictions on individual freedom for collective benefit.

7.1 Methodology

A total of 96 focus groups were held in September and October 2003 within 16 European countries of these: Austria (Linz, Vienna), Belgium (Antwerp, Liege), Denmark (Copenhagen, Vejle), Finland (Helsinki, Jyväskylä), France (Paris, Tours), Germany (Hamburg, Leipzig), Greece (Athens, Salonica), Republic of Ireland (Cork, Dublin), Italy (Milan, Rome), Luxembourg, Netherlands (Amsterdam, Eindhoven), Poland (Krakow, Warsaw), Portugal (Lisbon, Oporto), Spain (Barcelona, Madrid), Sweden (Örebro, Stockholm), and the UK (London, Glasgow). Additional pilot groups were previously held in the UK and France to test the question topic guide.

Focus group participants (with an average of 8 people per group) were recruited by Market Research companies in each country via a range of techniques: telephone directories, recruiter database of contacts, door-to-door or on-street recruitment. In order to obtain as representative sample as possible a screening questionnaire was used. For example, potential recruits were excluded if they were “*very active in working for political issues*” or who had absolutely “*no interest in current political and social issues*”, or who worked for the government, in marketing or the health industry. Thus efforts were made to reduce the chance that focus groups discussions would be biased by people with strong views in favour or against the policy issues discussed. The groups were segregated according to gender; age (20-30 or 45-60 years); marital status; parental status, educational status; and smoking status.

The focus groups each lasted approximately 2 hours and were conducted in the appropriate local language. The same topic guide was used for all groups (see Appendix 1). However, because of time constraints, not all groups were able to cover all policy areas. For example, 72 focus groups discussed smacking of children; 68 discussed water fluoridation; 94 discussed smoking policy; 89 discussed drugs policy; 66 discussed immunisation and 72 discussed smacking of children. The focus groups were tape-recorded, transcribed, and translated into English. These transcripts were then analysed and coded manually by the first author using techniques drawn from grounded theory.¹³⁷ Finally the types of arguments and general mood of the groups was compared and contrasted between demographics. Quotations in the results are used to illustrate the key emergent themes and arguments used. Focus-group quotes are identified by the location of the group, gender, age range (20-35 or 45-60), marital status, parental status, higher or lower education and smokers or non-smokers.

While focus groups do not measure strength of options held, they are particularly effective in highlighting both arguments used and the social and cultural context for individual beliefs¹³⁸ as well as raising questions and perspectives that may not naturally occur during other qualitative methodologies.¹³⁹ The focus group methodology enabled participants to discuss issues that they may not have previously considered and to form or challenge their opinions

through discussions with other people.^{140 141 142} Focus groups are a particularly useful methodology for establishing shared frames of reference and meaning in relation to how cannabis and the legalisation of cannabis which were used to produce and defend individual options and experiences. The number of focus groups conducted was large by qualitative standards, but the number of groups in each country or involving specific demographic categories was proportionately less. Care must also be taken in when making comparisons between countries and demographic groups to take into account historical and legislative differences as well as linguistic issues.

7.2 Prohibition of smacking of children

7.2.1 Opinions on smacking

This issue was highly polarising across demographic types and countries. There were distinctly different views on whether smacking was harmful. The discussions were often emotive and there were sometimes angry exchanges from those who passionately disapproved of smacking at any level with those who did not. Participants with children were equally divided against smacking or for smacking, though they thought there were better ways to discipline children. Older participants appeared more against smacking than younger participants and in general, females were more against smacking than males.

In countries where all forms of smacking is already illegal e.g. Sweden, Finland and Denmark, it appeared that anti-smacking beliefs were more entrenched than other countries. They felt that society could and should manage without smacking, and that ultimately parents did not have the right to smack their child.

“It is a disgrace to take advantage of the helplessness of children. I don’t see how it could be necessary in any situation”.

Finland/female/45-60/married/children/further education

Several people stated that they had been smacked as children and had suffered no ill effects, this was seen across age groups, countries, gender and whether they had children or not but was more prevalent among older respondents.

“A clip around the ears hasn't done us any harm either”

Germany/male/45-60/married/children/further education

Others thought it a good form of discipline which even though not ideal was necessary and possibly unavoidable.

“I think people even have the right to make that a part of their upbringing”

Netherlands/female/20-30/single/no children/further education

Some respondents suggested that some children are uncontrollable any other way and that children should be spanked more.

“There are children who do not react to anything else anymore”

Austria/female/45-60/single/no children/further education

One person stated that it was part of their tradition.

“I think that smacking a child as punishment is part of our tradition. However, there are limits to it and it shouldn’t get out of hand.”

Spain/male/45-60/married/children/standard education

A number of respondents mentioned that they thought discipline among young people was better when corporal punishment was allowed and that children were now uncontrollable.

“Nowadays our society suffers from the lack of spanking”

Italy/female/45-60/single/no children/standard education

Some felt children should be treated in the same way as adults and given the same respect and that there were better ways to discipline them for instance, denying treats, discussion, grounding etc.

“-Can you give me one justification why I can slap a child? I am not slapping you as an adult, either, do I? I really find that unbelievable.

-But I also think it is important to show children where the limits are!

-But you can do that in a discussion!”

Germany/female/45-60/single/no children/further education

Some believed that smacking made children more aggressive and that violence can breed violence. They thought that teaching children that hitting is an appropriate way of resolving conflict could contribute towards a more violent society.

“This aggression cumulates and in the future he’ll beat his parent”

Poland/female/45-60/married/children/further education

Some were worried that smacks can get harder, sometimes involving implements, can then escalate to beating, on to abuse and that it leads to further violence. They thought that smacking could get out of control.

“That one smack, then a child doesn’t do it the next time, then he gets two smacks”

Netherlands/female/20-30/married/children/standard education

7.2.2 Opinions on smacking bans

No consensus was reached either across demographics or across countries on the benefits of having a law against smacking children in place. However in countries where smacking has been banned for some time, respondents were much more in favour of legislation than elsewhere.

The primary reason for rejecting the government’s right to legislate in this area was an infringement of civil liberties and parental rights. This was not seen as a problem in Scandinavian countries but in other countries, it was felt that perceived government interference and invasion of privacy would lead to an unacceptable loss of parental rights.

“Yes, but you do have the right to raise your child, if you think that’s the best way to raise it.”

Belgium/female/20-30/single/no children/standard education

Some thought that a law would protect the minority - those who were being abused.

“I think it should be a law, this way we can save children who are really beaten and have bruises”

Finland/female/45-60/married/children/further education

However, the majority felt that the rationale of protecting vulnerable children from abuse was not sufficiently compelling. Very few felt that banning smacking would protect an individual child from abuse.

“The ones who are really mistreating their kids will do it anyway. So the people who are actually affected are the parents who want to spank their kids”

Denmark/male/45-60/married/children/standard education

This was because they felt that crimes occur despite laws.

“Sexual abuse of children is forbidden, too, but evidently it happens nevertheless.”

Austria/female/45-60/single/no children/further education

Others stated that although it may not be effective in protecting the minority, legislation was felt to raise awareness of the abuse issue in society and send an unequivocal message about it being harmful and parents may think twice before smacking.

“No, it doesn't protect them, but maybe it would make the public more aware. People hitting their children are well aware of the fact that they are not allowed to do that. So if it is made illegal, this doesn't really protect the child. But these people know they will be punished if it comes out in the open.”

Austria/female/20-30/single/no children/standard education

One Swedish group, where a law against smacking has been in place for some years, felt that even though smacking still occurred in Sweden, the law had resulted in a reduction in the incidence of slapping.

“But, you know, kids get slapped even in Sweden, or get their bottom spanked, or, but it's less than it would be without this law.”

Sweden/male/45-60/married/children/further education

Some groups mentioned that a law would give observers the right and the power to make a report to the authorities.

“But at least in that case, if the neighbours hear what is going on, they can do something about it. If the appropriate laws do not exist then you can't do anything about it at all”

Germany/female/20-30/married/children/further education

However, some groups were worried that a law could result in the false reporting of neighbours, if for instance there was some animosity between them.

“-I've got something against my neighbour ...- I'll report that he hits his kid.”

Belgium/female/45-60/married/children/further education

A few groups worried that the law could result in inappropriately strong punishment for parents, or punishment that was too extreme for the crime.

“Parents will be punishable if they ill-treat their children, if they beat them up. But it will be absurd only for a smack.”

Italy/female/45-60/single/no children/standard education

Concern was voiced about children rebelling against their parents and being able to threaten their parents with the police which would lead to an undermining of parental authority.

“In that case we would soon have children reporting their parents to the police, because they slapped them.”

Austria/female/20-30/single/no children/standard education

A critical problem for many is that it appears unworkable as a law – it was an intrusion of the State, smacking was essentially a personal choice and banning this is the *thin end of the wedge*, a slippery slope for further government interference, and that there would be non-compliance.

“There are certain areas where the state just can’t go any further, can the law go into the bedroom, into the house, how far can the law go, how can the state monitor that.”

Ireland/male/45-60/single/no children/further education

“I would continue to raise my children in the way I think is right.”

Austria/male/20-30/single/no children/further education

7.2.3 Discussion

A 2001 UNICEF opinion survey of 15,200 young people, aged 9-17 years across 35 countries in Europe and Central Asia, found six out of ten children reporting violent or aggressive behaviour within their families.¹⁴³

Seventy two percent of children in Finland¹⁴⁴ and 91% in Ireland¹⁴⁵ had been slapped or smacked in childhood. In the UK a study found that although three quarters of respondents agreed that smacking is not an appropriate way to handle the unsafe behaviour of a three year old child, almost two thirds of the sample had smacked their pre-school child in the past week.¹⁴⁶

Legislation against smacking in schools and in the home currently varies across Europe. In the countries in this study, all except France already have a law in place that bans corporal punishment in schools. Austria, Denmark, Finland, Germany, and Sweden currently have laws explicitly prohibiting the physical punishment of children in the home.¹⁴⁷ Italy and Portugal are in the process of having a law confirmed in legislation. Certain countries such as the UK have tried to distinguish between disciplining children and abuse by allowing mild smacking that does not cause visible bruising, grazes etc under a *reasonable chastisement* defence against common assault.

The focus group analysis did not observe strong demographic variations between the perceptions and arguments of the focus groups however older participants and females appeared more against smacking than younger or male participants.

Both professional and lay opinion is divided on the use of smacking as a form of discipline of young children.¹⁴⁸ Some believe that smacking is an important component of discipline and essential for normal social development.¹⁴⁹ Others believe that smacking is at best ineffective and at worse leads to an escalation of unwanted behaviour or abuse.^{150 151} This range of opinions was observed in the focus groups of this study.

Limited research has been published on public opinion to smacking. A 2004 survey of 1,007 adults in the UK, found that 85% agreed that “*parents should sometimes be allowed to smack their children*”. Only 12 per cent agreed that, “*smacking of children by their parents should be illegal in all circumstances*”.¹⁵² A survey done in the USA found that 51% of the parents supported the use of corporal punishment in schools.¹⁵³ Another USA survey found that 19% of mothers believed that there are times when it is appropriate to spank a child less than 1 year old, and 74% believed this about children 1 to 3 years old.¹⁵⁴ A 1998 UK survey of 2,000 adults showed that 88% agreed that “*it is sometimes necessary to smack naughty children*”, with only 8% disagreeing.¹⁵⁵ A Scottish survey found that 83% of respondents thought it should be lawful for a parent to smack a 9 year old.¹⁵⁶ These surveys stand in marked contrast to the results of a MORI poll conducted in the UK on behalf of the Children are Unbeatable Alliance¹⁵⁷, which suggest that the majority of the general public supports a change in the law on smacking. The explanation for this discrepancy may be due to the language used in the MORI poll questions, which referred to “*hitting family members*” without allowing respondents to make a distinction between moderate physical correction and violent attacks. In the focus groups in this study, it was made clear that the discussion was about mild physical punishment.

Making decisions about the upbringing of a child is usually within the rights of the parents but it is their responsibility to do this within socially acceptable norms. Children may be taken into the care of the social services if certain boundaries are crossed, for instance if children are seriously harmed or abused. Most member states of the United Nations have ratified the UN Convention on the Rights of the Child which obliges States to “... *take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child*”.¹⁵⁸

Professional opinion is divided on the ability of legislation to bring about change in social attitudes and behaviour. A review of the effects of Sweden’s ban on smacking found little change after the ban¹⁵⁹ finding that in a 1994 Swedish survey that corporal punishment was just as prevalent after the ban as it was before.¹⁶⁰ Another study found that public support for corporal punishment had declined and that the ban had been highly successful.¹⁶¹

However, the UNICEF report¹⁴³ showed that death rates due to maltreatment are virtually identical in countries with smacking bans compared to those without them. In fact, none of the four countries with the lowest child maltreatment death rates (Spain, Greece, Italy and Ireland) has a ban on smacking.

The debate on smacking remains polarised. The right of a parent to choose whether to smack a child appears strongly defended in all countries in our study except Sweden and Finland, where legislation has been in place for some time. The primary reason is a curtailment of their parental rights rather than a belief in the rationale that was offered to them in discussion – namely that legislation restricts the freedom of the many to protect the few. Moreover perceived problems with defining and enforcing such legislation undermines its credibility. It is clear that public opinion is crucial to the effectiveness of a ban on smacking and an individual’s *moral commitment* to a law is linked to whether or not they will obey the law.

7.3 Wearing of car seat belts

Support was expressed for the use of car seat belts in most focus groups. Support was particularly strong in The Netherlands, Sweden and the UK. Wearing seat belts was seen as being in everyone's best interests and justified paternalistic legislation.

"I don't wear my belt because of the law; I wear it for safety".

Denmark/male/20-30/married/children/standard education

"I think sometimes people have to be forced to do something and that makes obvious sense to wear a seat belt. There's no reason why anybody shouldn't wear a seat belt".

UK/male/45-60/married/children/further education

Some participants gave personal examples of why wearing seat belts is important:

"Because I don't want to be thrown...because one of my colleagues was thrown through the windscreen and he lost his sight."

France/male/45-60/married/children/further education

The majority also supported seat belts in Poland, Luxemburg and Spain although reluctant and opposing views were more strongly presented. Some individuals held strong views against any form of legislation and refused to wear a seat belt at all.

"I don't fasten my seatbelts and I will never do it because I simply don't like it. Even if I pay a fine I will still drive without fastening seatbelts".

Poland/male/20-30/married/children/standard education

7.3.1 Infringement of Personal Freedom

An argument used by those opposing seat belt legislation was that it should be an individual's own choice to wear a seat belt, as not wearing one posed little or no threat to anyone but the individual in question.

"I consider the inside of a car to be free space, like the inside of a house."

France/male/45-60/married/children/further education

Civil liberty arguments were frequently criticised within the groups and it was pointed out that even if the *direct* costs by an individual not wearing his or her seat belt are slight, *indirect* costs do exist, and have a potentially critical impact of justifying necessity.

"But if you have an accident and end up in a hospital, and you're handicapped for the rest of your life, then the community pays for all that."

Belgium/female/45-60/married/children/further education

The opinion that each individual should think beyond restrictions in personal liberty and more towards community advantages was common. Some group members took the topic further.

"At the danger of sounding extreme again, in my opinion there are certain basic laws that have to be observed. Otherwise life in a community does not function."

Germany/male/20-30/single/no children/standard education

7.3.2 Risk of Accidents

Some participants did not believe that the risk of serious injury was great enough to warrant frequent belt use. Even those individuals who generally supported seat belt use admitted non compliance in some circumstances. There was an association between perceived risk of having an accident and journey length.

“I think being truthful it depends what journey I am going on, if it is a long journey I put my seat belt on, if it is a short journey I am being lazy, I sometimes don’t ..But if I was going on a long journey, yes, I would put a seat belt on ..I know it sounds stupid, you have got more chance of something happening.”

UK/male/20-30/married/children/further education

However, others recognised that any length of car journey was associated with risk.

“You can sit in the car for five hours and nothing happens, you can be in the car for five minutes and can be totally, totally collided and dead”

Netherlands/female/20-30/married/children/standard education

The risk associated with seat belt compliance differed from that of other traffic regulations. This was often used to promote seat belt necessity.

“Being a responsible driver I wear a seat belt and am protected. However things like red lights are a different issue. According to the law I am not allowed to cross red lights. I don’t do it, and I especially don’t do it if there is other traffic around. If the lights are red however, and no car is to be seen or even heard anywhere, of course I go through the lights.”

Germany/male/20-30/single/no children/standard education

7.3.3 Law Enforcement

The separate issue of being caught by the police for non-compliance was perceived as a powerful factor in legislation enforcement.

“I’m talking about the authorities, the cops and everybody else, given the fact that they don’t fine people for [not wearing seat belts] then it must mean they’re not entirely convinced by it either.”

France/male/45-60/married/children/further education

If those enforcing the law do not do so adequately the public may assume reasoning behind legislation to be weak. Some participants were also of the opinion that a good example should be set by law enforcement authorities.

“I have seen policemen in the car in front of me not wearing a seatbelt. That’s not exactly serving as a good example”.

Germany/female/20-30/single/no children/standard education

7.3.4 Habit

Habit was frequently used to reinforce both compliance and non compliance arguments.

"I've been damaged by work, I guess. Because I jump into different vehicles all the time, so it's impossible, that is, it's too much hassle. And then, unfortunately, you take that with you home".

Sweden/male/20-30/married/children/further education

"I have been told to wear a safety belt since I was a child, so it is instinctive".

Finland/female/20-30/single/no children/further education

7.3.5 Setting an example for children

In focus groups where participants were parents, a large majority made their children wear seat belts in both the front and rear seats for safety. It was also expressed that educating children in this way had the capacity to change a parent's behaviour.

"I used to be careless in driving. But when I had my child, from then I always wear a seat belt because I think, if something happens to me what will happen to my child, and I always put the child in the safety seat because I think, if something happens to my child, what will happen to me?"

Greece/female/20-30/married/children/standard education

7.3.6 Discussion

Traffic volume within the European Union has tripled over the last 30 years, though the number of road deaths have fallen by half. Despite these reductions the EU has stated that the figures are still too high and have set new targets.¹⁶² Over 41,000 people were killed across Europe in road traffic accidents in the year 2000, and it has become the primary cause of death in 14-25 year olds.¹⁶³ The European Commission plans to halve this number by 2010, as set out in the White Paper on European Transport Policy. However, the European Transport Safety Council (ETSC) reported only a 17.5% reduction in road traffic fatalities in 2005, well below that projected, and needed 25% at this stage for the European Union to hit its target.¹⁶⁴

With non seat belt use being one of the three major aggravating factors for fatal accidents, alongside speeding and driving under the influence of alcohol¹⁶⁵, increasing seat belt compliance would be hugely beneficial in achieving the 50% reduction. It has been estimated that universal seat belt use, to the best international rate, could prevent more than 6,000 deaths and 380,000 injuries a year within the original 15 European Union Member States.¹⁶⁶

In 1991, the European Commission passed a Directive (91/671/EEC) requiring that a seat belt must be worn in both front and rear seats in all vehicles less than 3.5 tonnes.¹⁶⁷ This was revised in 2003 (Directive 2003/20/EC) extending the obligatory use of seat belts to occupants of all motor vehicles, including trucks and coaches.¹⁶⁸ As of 9 May 2006 the latest Directive had to be transposed into national law in all Member States. It is the duty of the individual Member States to enforce such legislation and improve seat belt usage and road safety.

Incorporating seat belt legislation into national law is only one step to improving widespread seat belt use. In order to benefit public health, the legislation must be publicised, explained and, if necessary, enforced. Factors influencing public understanding and attitudes to seat belt legislation include socio-economic differences, population density, age, fatalistic attitudes and law enforcement.^{169 170 171}

Most focus group participants were convinced of the benefits of seat belt use and hence restrictions in personal freedom may be perceived as less severe if one wears a seat belt habitually.

Classically a north-south divide exists across the European Union, with northern countries having a higher overall rate of seat belt use than other Member States.¹⁷² The differences are so stark that whilst the Southern and Eastern Member States represent only 34% of the European Union's population, 54% of all road deaths occur in these countries.¹⁷³ The European Transport Safety Council (ETSC) stated in April 2006 that seat belt wearing rates in the EU vary between 59% (Hungary) and 97% (France) for the front seat and 21% (Estonia) and 90% (Germany) for the rear seat.¹⁷² This is despite all countries requiring use of seat belts. Differences in belt use can be largely attributed to effective planning and implementation of legislation.

Only 1% of non seat belt users are totally against seat belts.¹⁷⁴ They generally do not acknowledge the benefits of seat belts and are opposed to their use. Many *hard core non-users* object to being forced to buckle up, believing that belt use should be a matter of personal choice.¹⁷⁵ People within the focus groups who refused to wear seat belts were rare, but those that did cited civil liberty arguments as justification.

Habitual behaviour has been recognised as one of the most influential factors in improving overall compliance rates¹⁷⁰ and its importance is reflected in the focus group data, being used to reinforce reasoning for both regular and irregular use of seatbelts. The focus groups highlighted the inconsistencies in seat belt use dependent on the journey taken and the perceived risk of having an accident, despite a widespread agreement on the safety benefits of seat belts. People who do not always use seat belts understood the importance of wearing a seat belt, but did so inconsistently due to the predominant effects of habit. SARTRE 3¹⁶⁴ also found that people were less likely to wear seat belts in built up areas compared to motorways or other main roads.

People who do more driving each year (more than 10,000 km) were less likely to always wear seat belts.¹⁷⁰ These frequent drivers may need to use vehicles as part of their work. Some of the focus group participants described how occupational work patterns could reinforce bad habits for seat belt use.

SARTRE 3¹⁶⁴ found that drivers who use seat belts less frequently tended to underestimate the benefits of wearing belts if one drives carefully and overestimated the risks of being trapped by the belt in case of emergency. The report also recommended that education and information campaigns were necessary to improve understanding of the benefits of seat belt wearing.

Although no significant demographic differences were apparent from the focus group analysis, those participants who had children were more likely to recognise the safety benefits

of wearing a belt. SARTRE 3¹⁷⁰ found that those drivers who always made children wear a seat belt or restraint was a significant predictor for the driver wearing a seatbelt themselves.

The problems identified in the focus group data regarding law enforcement are a cause for concern. In order to effectively promote seat belt use it is necessary for the police to adhere to, as well as enforce the law, especially with such strong majority support for seat belts. There are two main ways in which law enforcement is most effective. Either more fines are issued by the police or an increased perception of being fined is created with effective use of the media. Maximum benefit is most likely through a combination of the two.¹⁷⁶ A USA study observed a clear relationship between belt use and the perceived risk of being ticketed.¹⁷⁷ It is important to note that individual risk perceptions of being ticketed appeared to be irrespective of the *actual* chance of receiving a ticket.

SARTRE 3¹⁷⁰ found that the percentages of drivers who were fined or punished in some way for not wearing seat belts in the last 3 years was between 10% and 20% in Estonia, Slovenia, Slovakia, Croatia and just over 20% in Cyprus. The percentages in other EU States were less than 10% and many were less than 5% (lowest in UK). The proportion of drivers who were fined or punished for not wearing a seat belt was low for countries where the wearing rate was highest. However, comparison of wearing and punishment rates suggested that non-users are punished relatively infrequently in many countries.

ETSC recommend that the best way to enforce seat belt use is through intensive and highly visible specific seat belt actions. Such *blitz* enforcement should last only one to four weeks and be repeated several times a year. These could be combined with other enforcement actions, for example on drink driving to be a more cost-effective use of police resources.¹⁷⁶

If seat belt compliance rates can be improved in drivers who use them some but not all of the time, the likelihood of the EU reaching its 2010 target may be significantly increased. The ETSC has endorsed the use of seat belt reminders in new cars as a cost effective intervention aimed predominantly at this group and suggested that reminders can increase compliance rates to 99%.¹⁷⁴

It is doubtful that seat belt reminders alone will be enough to promote vast attitudinal change. However, combined with education and other interventions, it may be possible to not only improve immediate compliance rates but also long term adherence to legislation. In order to achieve such long term effects, focus groups recognised that paternalistic legislation, provided it is appropriately enforced, can be an important motivation factor to encourage people to do what they recognised is in their own best interests.

7.4 Decriminalisation of cannabis use

The cannabis discussion was focused upon the perception of cannabis as a soft drug, its use by youngsters, advantages and disadvantages for society, potential limitations of use and purchase.

In two countries, Belgium and Denmark, there was extensive discussion of the cannabis question, which is likely to be related to the recent public debates regarding cannabis legalisation. In the other countries there were still mixed responses, but less discussion which is likely to reflect a difference between knowledge and experience of drugs, rather than being directly related to gender, education level, or national boundaries. Only in the Dutch and Danish groups was cannabis raised by respondents themselves as a person's own choice, which is likely to be related to the policy of tolerating personal possession in those countries. Overall the groups consisting of younger men were more positive in tone regarding cannabis and its de-legalisation. The focus groups with older participants remarked more often that cannabis was a hard drug (dissimilar to alcohol and tobacco) and were against legalisation. There was also confusion as to why the government would legalise a drug such as cannabis while at the same time restricting life style choices such as smoking.

Nearly all individuals expressed agreement that cannabis should be legalised for medical treatment by prescription if their doctor felt it would benefit a patient.

"On medical grounds yes but then it's prescribed by a doctor"

UK/female/45-60/married/children/standard education/non-smoker

7.4.1 View of cannabis as a soft or hard drug

The main difference in options between group participants was how they conceived of cannabis as a drug. The view of cannabis as a hard drug seemed to be central to arguments against legalisation of cannabis. Many of these respondents disagreed with the distinction the moderator made between the idea of *soft* and *hard* drugs:

"Except that there aren't any soft drugs, and marijuana is a drug, and there are no softer drugs."

Sweden/female/20-30/married/children/standard education/smoker

"A drug is a drug and there should be no differentiation between soft and hard, however you put it. That has to be drummed, it has to be drummed into every head so to speak, drugs are rubbish, drugs do not belong..."

Germany/male/40-60/married/children/standard education/non-smoker

For those that supported the legalisation of cannabis, as a soft/light drug, they drew upon its significance as a *natural* drug.

"Yes, because cannabis is a natural product after all"

Netherlands/female/45-60/married/children/further education/non-smoker

Respondents who voiced options supportive of cannabis legalisation saw cannabis as a *soft* or *light* drug similar to socially accepted drugs such as cigarettes, coffee and alcohol. Thus

some respondents drew on tobacco to argue that cannabis should be legalised in a similar way.

“It’s not a drug; it is rather comparable to cigarettes.”

Austria/females/45-60/single/no children/further education

However the view of cannabis as being similar to alcohol was also used by some *anti respondents* to argue that it had similarities for misuse.

“We have seen how it is with alcohol. Many people start with beer or cider, and move on to spirits.”

Finland/female/45-60 /children/standard education/no smoking

Overall alcohol was considered to cause more anti-social problems and violence. The view that cannabis was a soft drug led respondents to believe that it, like alcohol could be used in moderation.

While creating new users was not a concern for those who viewed cannabis as a soft drug, it was a concern for those respondents who saw cannabis negatively and some feared that legalisation would attract new users.

“I’m against it because all the weak people will find it much easier to get hold of and then they’ll start using it. That group... the weak group, who are easily influenced...”

Denmark/male/45-60/single/no children/further education/smoking mix

Thus in some cases respondents thought the line should be drawn at *chemical* drugs because they saw these as being more harmful.

“And that’s where the line is. And then you stop there when that’s where the line is. Chemically. And that’s more clear than what we have in Belgium right now I think. I know people who are convinced that their E’s aren’t harmful at all.”

Belgium/male/20-30/married/children/further education/smoker

A second concern expressed by respondents was the potential effects of cannabis on physical and mental health. Respondents viewed the governments’ control of tobacco as justified because it caused physical dependency, whereas cannabis did not.

There was some debate between respondents as to the impact of drugs upon a person’s capacity to make decisions:

“You don’t lose your judgement after a cigarette, but your judgement goes after ... No, but you lose it after a bottle of spirits, I’d say.”

Sweden/female/20-30/married/children/standard education/smoker

Some respondents believed that cannabis had a long term impact in this regard.

“I believe that when used as a narcotic it will affect your brains and your thinking. It will make your attitude somewhat impassive and apathetic. It stultifies you”

Finland/female/45-60/married/children/further education/smoker

For some respondents this would mean cannabis users were likely to use public resources in the form of drug rehabilitation centres.

7.4.2 Gateway drugs

Some respondents who were against the legalisation of cannabis voiced concern that the legalisation of cannabis would not only create new users but also act as a *gateway* drug.

“I’m shaking my head because I know people who have started off with cannabis amongst friends, children, and they’re now on the next levels and it’s horrendous”

UK/female/45-60/single/no children/further education

This was an added concern as people were thought to become involved in harder drugs through buying cannabis from dealers who offered harder drugs.

“If you are involved in that circle they will try and sell you something else.”

UK/female/45-60/single/no children/further education

7.4.3 Crime

Respondents thought that legalisation may impact on crime if more people would become addicted and as a result crime would increase.

“And the assaults and thefts would increase and everything. They just must get that cannabis, and they would not get it from shops, would they?”

Finland/female/45-60/married/children/further education/smoker

Other respondents argued that legalising cannabis would not close down dealers, but rather move the dealers onto selling harder drugs.

“All those cannabis dealers aren’t going to go and find themselves another job if cannabis becomes legal. What they’ll do is probably start selling something else. If you look at places like Spain, when they can’t deal in cannabis anymore, they just start dealing in (...) heroin or cocaine.”

UK/male/45-60/married/children/further education/non-Smoker

For those who held the option that cannabis was a soft drug, its use also did not directly involve crime, rather it was the current law which led to a tacit support of organised crime.

“Thus, people who use cannabis are actually supporting organised crime, prostitution, illegal weapons trade and things like that.... So I would like the legislation to concentrate on keeping organised crime, prostitution and drug sales under control. I would suggest changing the practice of the law in stead of legalising cannabis.”

Finland/male/20-30/married/children/standard education/smoking

In most cases the groups’ discussions regarding cannabis legalisation concluded that it should remain illegal but that personal possession should not be prosecuted. In those countries with a history of alcohol prohibition (notably Finland) respondents argued that the illegality of the drug caused many associated problems and thus the government should punish dealers.

“Punish dealers, but not consumers, given that there is an increasing mentality which says that drugs which are addictive...victims more than culprits...”

Luxembourg/male/20-30/single/no children/standard education/non-smoker

Some respondents supported a similar move on pragmatic grounds.

“This is about not wasting effort on things that will happen anyway.”

Netherlands/female/45-60/married/children/further education/non-smokers

7.4.4 Personal right

In nearly all the Danish and Dutch groups (countries which both have areas where cannabis is perceived as ‘semi-legal’) many participants referred to civil liberty and personal freedom.

“Actually everyone should have the right to decide for themselves.”

Netherlands/female/20-30/married/children/standard education/smoker

In some other countries, such as Austria and Sweden, a few respondents also expressed this view.

“If somebody thinks he has to do it, he will find out where he will end up. You have to give human beings the freedom to find out where it will take them.”

Austria/male/20-30/married/children/standard education/smoker

In similarity with the options expressed by some respondents regarding smoking tobacco, cannabis use was seen as personal and acceptable as long as people’s actions did not hurt anyone else.

“That we have a right to choose if we want to smoke or not smoke [cigarettes], as long as it doesn’t hurt anyone else, then I think, in that case, that we have the right to choose if we want to smoke cannabis or not”.

Sweden/male/45-60/married/children/further education/non-smoker

This was made explicit as any ‘harm’ was only inflicted upon themselves.

“I smoke cannabis. Ok, that’s my choice because I feel I harm nobody around me. And personally I think it’s ok, I mean, I don’t think it makes me antisocial.”

Belgium/male/20-30/married/children/further education/smoker

7.4.5 Government control

The focus group question was used to prompt a discussion to the role of the government in legalisation of cannabis and the potential benefits. In those groups where the predominant feeling was that legalisation was positive, respondents also supported the increased involvement of the government as potentially improving the quality of the product. This was seen as important as respondents believed that good quality drugs were not so harmful.

“But it seems that good quality drugs are not so harmful (...) So there should be controls on the quality of the drugs.”

Spain/male/45-60/married/children/standard education/non-smoker

Some respondents felt that market forces and government control would create a better product, while they had been unable to do so with cigarettes because of the power of tobacco companies. Some respondents envisioned cannabis being *cleaner* under government control.

“Hash will be clean.(...) I mean you can put all sorts of stuff in hash nowadays. You can go down to Dannebrogsgade street and Vesterbro area and there may be some deodorant or other random stuff they stick in it, you know?”

Denmark/male/45-60/single/no children/further education/smoking mix

In contrast to the view that government involvement was a positive step, some anti-legalisation respondents believed government involvement and regulation would be seen as condoning drug use. These respondents expressed confusion as to how the government could be trying to encourage people to give up smoking while legalising cannabis.

Certain respondents also were of the option that the regulation of cannabis by governments could bring benefits to society as a whole i.e. via taxation. Thus some Dutch groups remarked that their current system could be seen as beneficial as it brought tourists. Taxation was seen, even by some non-cannabis users, as a pragmatic reason for government involvement in the cannabis trade.

“Because in Denmark, there is – no matter how you look at it – there is a trade in cannabis. And so we might as well try to get some money out of that so as to do something about the other narcotics”

Denmark/female/20-30/single/no children/further education/smoker

7.4.6 Education

Many of the respondents felt that the government’s role was to inform its citizens rather than directly regulate their actions and choices, and thus they suggested that education regarding the consequences of drug use was the most important thing.

“Then I think that hash should be legalised. And then there should be information campaign.”

Denmark/male/45-60/married/children/standard education/non-smoker

In some cases respondents who were against legalising cannabis expressed the view that if it were to be legalised, it should follow the Dutch system with similar restrictions. These respondents voiced the option that this would allow greater education and information, while also tightening certain restrictions (i.e. age restrictions). Thus the legalisation of cannabis was also seen by some respondents as allowing an open discussion and greater information could be given to cannabis users.

“At least when I look in France (...) it’s completely hidden under the carpet and yeah, I don’t think that’s a solution either. In any case, what I see happening in the Netherlands slowly, is that an open discussion is now slowly possible, where a couple of experts try to do research, to get a clearer picture of what the effects are.”

Netherlands/male/40-65/married/ children/further education/smoker.

7.4.7 Discussion

Cannabis is by far the most commonly used illegal substance in Europe. In Belgium, Estonia, Hungary and Portugal between 5–10 % of the population has used cannabis, and this rises to 24–31 % in Denmark, Spain, France and the UK.¹⁷⁸ In recent years there has been increasing public debates as to the advantages and liabilities of the legalisation or decriminalisation of cannabis. Cannabis is progressively viewed as a *lifestyle drug* which is harmless in moderation, however, there is growing evidence that heavy and abusive use of cannabis may have multiple adverse consequences for personal function and health.^{179 180}

While national drug polices across the European Union seek to create a *drug-free society* their precise mechanism for achieving this varies. Some are based on limiting consumption behaviour while others focus on reducing the negative consequences of drugs for both the individual and society.¹⁸¹ With regard to cannabis, the major negative consequence is considered it's potential to act as a *gateway drug* particularly in reference to misuses of other illicit drugs.¹⁸² While the actual causal mechanisms underlying such a *gateway* are unclear¹⁸³, some countries, such as the Netherlands, have sought to separate *soft* and *hard* drug markets. In theory, by tolerating the sale of cannabis young people who experiment with cannabis are kept away from other illegal hard drugs.¹⁸¹ Indeed there is a growing movement within Europe to decriminalising personal purchase, possession and consumption of cannabis to focus on harm reduction.

It is often argued by pro-cannabis lobby groups that public opinion supports changes in legislation for cannabis use in the general population.^{184 185 186} Public attitudes towards legalisation of cannabis has been explored in Australia¹⁸⁷, the United States¹⁸⁸, Norway¹⁸⁹, and in Europe through the 2004 Eurobarometer.¹⁹⁰ National drug agencies collate drug related statistics but these are not focused on public attitudes.^{191 192} General attitudes towards legalisation between socio-economic demographics have been explored; however the majority of research has been based upon youngsters and risk groups.^{179 193}

Due to the variations between national drug legalisation the topic of decriminalisation of cannabis was raised in general terms, without specific reference to how the law could be changed. This is a concern as it has been shown that respondents can vary their support depending on the extent of *legalisation*.¹⁸⁷ It should also be noted that cannabis possession and use is not only illegal but also socially taboo in many countries and this was a concern when moderators sought to establish the experiences and attitudes of the respondents.

The legalisation of cannabis for use in the general population was met with mixed responses. Respondents were typically either in favour or against it depending on their view of cannabis as a drug. Those against legalisation generally saw cannabis as a hard drug and were concerned with the major mental health impacts and addiction. By contrast, those respondents who saw cannabis as a soft drug argued that when used in moderation it had few health effects and other licit drugs caused comparable harm (i.e. alcohol and tobacco). Research carried out for the popular media in the UK indicates this is a well supported view; 48% agree that using cannabis is no worse than drinking or smoking, while 34% disagreed, and 17% did not know.¹⁹⁴ The research reported here indicates that in similarity with alcohol and tobacco, cannabis use is seen by some as a *personal choice* which can be consumed in moderation as long as it does not harm others.

The increased normalisation of recreational drug use, including cannabis,¹⁹⁵ is likely to be linked to greater exposure of populations to recreational drugs. Throughout the European

Union cannabis use is concentrated among young adults; highest in 15 to 34 year olds (between 11-44% depending on country), predominantly male and more common in urban areas.¹⁹⁶ This study did not observe any strong socio-economic or gender variations between the perceptions and arguments of the focus groups. One possible reason for this is that cannabis as a licit drug is *normalised* not only in users but also in non-users.

The question of legalisation of cannabis was introduced to the focus groups in general terms, and in many cases respondents themselves argued that cannabis should remain illegal but that policing priorities should be changed. This is supported by the research carried out for the popular media in the UK which found that 66% of those surveyed supported legalisation of cannabis or that it should remain illegal but for the police to not prioritise prosecutions.¹⁹⁷ Thus 65% felt cannabis possession should be the lowest priority for the police, compared to other crimes such as street robbery, burglary, heroin use and car theft.¹⁹⁸ This is consistent with regard to the changes in several EU countries which have recently ratified laws liberalising the personal possession and use of cannabis.¹⁹⁹ In this study we found slight variations between age groups, with older groups expressing stronger opposition to legalisation. A similar age variation has been seen in the UK where 45% of 25 to 34 year olds agree with the legalisation of cannabis while only 27% of over 65's support this.²⁰⁰

This research also suggested that there was widespread support, by both those in favour of legalisation and those against, for greater drug information campaigns. Respondents called for these to include both information concerning health risks of cannabis and current laws related to possession and consumption. While the legalisation of cannabis or the toleration of personal cannabis use by police would be a step towards separation of hard and soft drug consumption, information campaigns would necessarily have an important role to play. This is especially true within the social environments which exposes youngsters to drugs and where licit and illegal drug use is *normalised*.

The normalisation of licit and illegal drugs is a growing problem throughout Europe which is unlikely to be successfully tackled through increased regulation and policing.^{182,183} The EuroPHEN data suggests that some respondents saw moderate recreational use of cannabis as comparable to the use of licit drugs such as alcohol, both in terms of health problems and anti-social behaviour. Respondents supported efforts to separate and regulate soft and hard drug markets to combat cannabis acting as a *gateway* to the unhealthy use of drugs (either excessive use of soft drugs or progression to hard drugs). While some people rejected the suggestion that cannabis was a hard drug, these tended to be within groups of older people in countries where exposure to cannabis is lower. It is possible that those who see cannabis as a harder drug may be less well informed or have less personal experience of usage themselves or among friends.

The research presented here raises the possibility that individuals are not primarily concerned with the safety of cannabis use itself, but rather with which policy is more effective in preventing progression onto drugs such as heroin or crack cocaine where there are clearer risks to individual and public health. Due to constraints in this project it remains to be explored whether pro-legalisation supporters see legalisation as the best way of stopping people progressing onto *harder* drugs or if opponents believe that for some, any *softer* drug use may inevitably place them on the slippery slope to destruction, and therefore all drug use (including alcohol) may be dangerous in this respect. If this is correct then opponents may argue the interests of adults who make autonomous choices, and are able to use cannabis *responsibly* without impact on their social obligations, but be outweighed in order to protect

vulnerable groups such as children, or those with more addictive personalities. However, this hypothesis is speculative and the focus groups did not discuss this specifically.

While it is possible to *de-normalise* drugs, as illustrated by the current change in social views of tobacco and smoking²⁰¹, such a policy would require massive resources and relies on a clear evidence basis that smoking moderate amounts of cannabis causes considerable harm. This research indicates that to counter cannabis acting as a *gateway*, it may be more effective to exploit the existing view that cannabis is a soft drug in contrast to other highly addictive and damaging hard drugs.

7.5 Water Fluoridation

Most participants in Austria, Belgium, Denmark, Finland, France, Germany, Italy, Luxemburg, Netherlands, Portugal, Spain and the UK were opposed to water fluoridation. In comparison, most participants in Greece, Ireland, Poland and Sweden were supportive. In part, this pattern reflects current or past experience of water fluoridation in these countries. However, it should be noted that in some countries only 1 or 2 groups discussed fluoridation.

7.5.1 Physical Harms

Many people were concerned about the health risks of fluoridation or fluoride overdose, particularly for children or others who may be more susceptible to harm. Some were aware of fluorosis or made links with other diseases e.g. bone cancer, arthritis, and mental retardation. However, the majority of participants did not specify what side-effects concerned them. People worried that supplementary fluoride in toothpastes, rinses etc. could combine dangerously with the levels proposed in fluoridated drinking water.

“I am taking fluoride supplements, tooth paste enriched with fluoride. And on top of that, drinking water! I will be totally fluoridated.”

Germany/male/20-30/single/no children/standard education

“I drink three litres of water a day – am I supposed to tell a child that they can only have one glass of water a day and that’s it? ... Because I’m an adult and I can cope with anything but some children might be harmed”

Spain/female/45-60/single/no children/further education

“It is the same as with the vaccinations, some can take it, others not.”

Austria/male/45-60/married/children/further education

Some participants noted fluoride is classified as a poison in their country or were concerned about fluoride getting into their bloodstream.

“But then you can also say that there’s fluoride in toothpaste, and there’s fluoride in that fluoride rinse. We always had to spit that out, and we spit out the toothpaste too. So why should we suddenly have something like that in our stomachs?”

Denmark/female/20-30/single/no children/standard education

7.5.2 The Purity of Water

People within the focus groups placed a great deal of value on their water being ‘pure’.

“I just love clean, pure water and I think it is polluting to add fluoride in it.”

Finland/female/45-60/married/children/further education

“I don’t think you should tamper with things like that ... I think you should keep things as natural as possible ... I don’t think it’s good for society.”

UK/female/45-60/single/no children/further education

Participants were suspicious of additions made by the authorities, although they recognised that chlorination is necessary to make water clean enough to drink.

“In Italy water was so good, but now we hold a record in selling mineral water. Because there is chlorine, there is atrazine. The State, in my opinion, should sanitize water we have and not adding anything.”

Spain/male/45-60/married/children/further education

Various participants were convinced that adding fluoride would change the taste or smell of water.

7.5.3 Rights, responsibilities and trust

Many saw fluoridation as an imposition on their freedom of choice, with the State making decisions for them rather than individuals taking responsibility for their own health.

“Things are being imposed ...It seems like they’ve got us on a leash. That’s it. - We’ve actually take no responsibility for ourselves, for our children. We’ve got no choice. They’re putting us in a mould. Take your vitamins morning, noon and night. They’re not telling us why it’s good. ...they want to make us rely more and more on their help ... we don’t have to think about anything any more.”

France/male/20-30/single/no children/standard education

“I just think that it’s a problem, doing this instead of getting involved at the root of the problem. There are some people who don’t teach their children the dangers of drugs or why you should brush your teeth, so we intervene. I mean we go along and say: ‘OK. We’ll take care of that for you. You don’t need to worry about that. ... You’re making a whole society of grown adults into people who can’t sort things out for themselves.”

Denmark/female/20-30/single/no children/further education

Many participants wondered what would else would be added to their water?

“Tomorrow we put fluoride in it, the day after we put something else in it, where does it stop?”

Luxembourg/female/45-60/single/no children/further education

“The Chinese for example would put some contraceptive or something like that into their drinking water simply because they have too many people.”

Germany/male/45-60/married/children/further education

“They’ll find that the population is over excited, they’ll put downers in the water also!”

Belgium/male/20-30/single/no children/standard education

It was clear that many in the groups did not trust their politicians or the experts they employ to act in the public’s best interests. There was also concern that harms may emerge in the future when it was too late.

“Do you know that the person that gave the expert evidence in Australia, the first thing he did when they put fluoride in the water was invest in some kind of gadget to take the fluoride out of the water going into his house ... Who the hell do you believe?”

UK/male/45-60/married/children/further education

"I think that a lot of stuff they add to our food now, they don't have a clue what effect it actually has on us. Then twenty years later you get some study or other and they say oh right, it's actually that E759 thing that has an influence on people getting cancer or losing brain cells."

Denmark/female/20-30/single/no children/standard education

Many felt dental health was an issue to be dealt with at the level of the individual, rather than a solution to be imposed en masse.

"It is like shooting at sparrows with canons."

Austria/male/20-30/married/children/standard education

It was pointed out that the policy would be ineffective as many do not drink tap water.

"I don't think that we drink that much water, we use it for the laundry. I don't like tap water ... I rather have mineral water or a coke. Whether this is healthy is another question, but I don't drink tap water."

Austria/female/45-60/single/no children/further education

Some participants did not see why they or their children (who had good teeth) needed to be subjected to (undefined) risks such that a minority may benefit.

"Well this is kind of "just" teeth, that's my feeling. I mean that the entire population of Denmark could get, could end up with too much fluoride, an accumulation and so on. I mean you can sort that out in some other way. You know perfectly well how to sort out problems with your teeth."

Denmark/female/20-30/single/no children/standard education

People expected either parents to take responsibility for their children's dental health or the State to ensure that they do. Many people who advocated these alternatives did so with the attitude that other children's dental health was not their problem and that the issue should be dealt with in a way that least interferes with their lives.

*"- Toothpastes are becoming cheaper and cheaper and all of them are with fluorine
- But there are some people who can't afford toothpastes.
- I don't agree. It would be better if the social care gave them money for toothpastes."*

Poland/male/20-30/married/children/standard education

"Instead of adding fluoride they could subsidise dentists more, couldn't they? "

Spain/male/45-60/married/children/standard education

Some people suggested as an alternative, tablets or rinses could be used to supplement fluoride levels so that those in need are individually targeted.

"You can give a fluoride tablet to your children daily. They like them, they enjoy having a little pill."

Finland/female/45-60/married/children/further education

Groups in some countries suggested that schools should take responsibility, either by providing toothpaste, brushes, and supervision, or administering tablets or rinses.

“At school they brush their teeth two times a day and they should do it more frequently”
Poland/female/45-60/married/children/further education

Some felt that if parents behaved irresponsibly and did not enforce tooth brushing and healthy diets then, social services should intervene.

“I think that in such a case the youth welfare department has to become active. These families are known to them.”
Germany/female/20-30/single/no children/standard education

7.5.4 Reasons Given For Fluoridation

Some people felt responsible for the wellbeing of other members of the community who were not as fortunate as themselves. As such they felt it was their duty to support measures by the government to help the socially disadvantaged.

“If there has to be fluoride in water and this will benefit the whole population, of course they have the right ... to protect poor people who don't have the income to take vitamins”
Greece/female/20-30/married/children/standard education

*“- Should the state have the right to make these choices for us?
- If it is for our health, yes - this is why we vote, we vote people to make these choices for us”*
Greece/female/45-60/single/no children/further education

*“- When they take note of the health, public health, I think it's ok
- Yeah, then they do have the right, not the duty, but a right”*
Netherlands/female/20-30/married/children/standard education

Some participants, mostly in Poland saw the addition of fluoride as another good initiative to add on to the success of chlorination.

“Yes, if it's not harmful. We already have chlorine in our tap water, so fluorine wouldn't make a difference. ... We were drinking chlorine for so many years so fluorine is not a problem.”
Poland/male/20-30/single/no children/further education

In countries where there had been fluoridation, many felt that they suffered no ill effects and therefore were supportive or at least did not oppose fluoridation.

“When I was a child I drank water enriched with fluoride. In the GDR this was common....I had white teeth”.
Germany/male/20-30/single/no-children/standard education

“Well I've drunk the water all my life and brush my teeth and hasn't done me any harm, so I go with what I know”.
Ireland/female/20-30/single/no children/further education

7.5.5 Conditional Acceptance

Where there was acceptance of fluoridation, it was often conditional upon one or more provisos being met. For example: the measure could not harm anyone, even if it benefited many people; there could be no change in water taste or smell; no increase water costs; an independent review to prove effectiveness and safety; public consultation or referendum.

“If we’re really sure that it’s safe, with no colour and taste, then it’s ok.”

Poland/male/20-30/married/children/standard education

“There should be a petition to ask people whether they want that... they could hold a referendum”.

Luxembourg/female/45-60/single/no children/further education

7.5.6 Discussion

A systematic review of the effectiveness and safety of water fluoridation concluded that *“the best available evidence ... suggests that fluoridation does reduce caries prevalence, both as measured by the proportion of children who are caries-free and by the mean dmft/DMFT score”*.²⁰² The report adds the caveat that *“the degree to which caries is reduced, however, is not clear from the data available”*. It also stated that the reduction in dental caries prevalence *“should be considered together with the increased prevalence of dental fluorosis”* but that *“overall, the studies examining other possible negative effects provide insufficient evidence on any particular outcome to permit confident conclusions”*. The report also noted that *“given the level of interest surrounding the issue of public water fluoridation, it is surprising to find that little high quality research has been undertaken”*. The scope of the review was therefore not broad enough to answer the question *“should fluoridation be undertaken on a broad scale in the UK?”* Instead the report recommended that *“research into the safety and efficacy of water fluoridation should be carried out with appropriate methodology to improve the quality of the existing evidence base”*. A full economic evaluation was also required as well as consideration of the ethical, environmental, ecological, costs and legal issues.

Despite the lack of clear evidence of cost effectiveness, water fluoridation has strong advocates and even more vociferous opponents.^{203 204 205 206 207 208} Indeed in October 2003 the authors of the York systematic review issued a statement saying that they were *“concerned about the continuing misinterpretations of the evidence and think it is important that decision makers are aware of what the review really found”*.²⁰⁹ They reiterated that the evidence of benefits and adverse effects were and that since their report was published in October 2000 *“there has been no other scientifically defensible review that would alter the findings of the York review”*.

There has been limited recent research on public opinions on fluoridation across Europe. Previous research was mainly in UK, and Scandinavia.^{210 211 212 213 214 215 216}

There seemed to be a majority among our focus groups across Europe against water fluoridation, apart from those countries where people have experienced fluoridation without adverse effects. Significant differences between the various demographic groups represented

were not detected, although the number of focus groups was large the number of citizens in each country was still relatively small.

The public generally perceive risks to be more worrying (and less acceptable) if they consider them²¹⁷:

1. To be involuntary (e.g. exposure to pollution) rather than voluntary (e.g. dangerous sports or smoking)
2. As inequitably distributed (some benefit while others suffer the consequences)
3. As inescapable by taking personal precautions
4. To arise from an unfamiliar or novel source
5. To result from man-made, rather than natural sources
6. To cause hidden and irreversible damage, e.g. through onset of illness many years after exposure
7. To pose some particular danger to small children or pregnant women or more generally to future generations
8. To threaten a form of death (or illness/injury) arousing particular dread
9. To damage identifiable rather than anonymous victims
10. To be poorly understood by science
11. As subject to contradictory statements from responsible sources (or, even worse, from the same source).

Public concerns around water fluoridation may be explained by many of these elements.

The participants were very familiar with the concept of adding substances to the water e.g. chlorine to make it wholesome, and with other food additives for health reasons e.g. vitamins or iodine. However, many had a poor understanding of the benefits and costs associated with fluoridation. They seemed unaware that water could naturally contain fluoride or that some bottled mineral waters actually have very high fluoride content.

Studies in the USA and South Africa have shown that many people did not know water fluoridation was intended to prevent tooth decay, although that knowledge was better in higher educated groups and among older people.^{218 219 220} Other studies have also found that the public are aware that fluoride can strengthen teeth, because they know that it is added to toothpaste.^{210 221} However, no demographic differences in knowledge or attitude were observed between our focus groups. The main concerns about water fluoridation for focus group participants were imposition on choice and responsibility, water purity, taste and the non specific risk of harm. Similar concerns have been found in studies in the USA and UK.^{210 211 221}

The main reasons given by people opposing water fluoridation in South Africa were: “*water should stay as it is*” (26%), concerns about it staying in the body (16%), and (negative) affect on health (12%).²²² Follow-up surveys in Norway (conducted in 1973 and 1983) and Denmark (1969 and 1975) found that public opinion had become more negative over time.^{214 215 216} Rise and Kraft thought that the public may not see water fluoridation as being necessary as dental health had improved through use of fluoride toothpaste.²¹⁶ They also noted the influence of the media and an increase in public’s ability to participate in political decision making.

While the UK public wished to be informed of plans for water fluoridation, they did not want to be involved in decision making about fluoridating their water, preferring such policy to be

left to experts.²¹² However in our research there seemed to be doubts about the veracity of experts. Schwartz and Hansen described how the announcement by a prominent dentist that he disagreed with the Danish Dental Association about water fluoridation led to public concern about conflict between experts and mistrust of the professional body.²¹⁵

Newspapers were the predominant source of information about fluoridation in the US.²²¹ Lowry noted that the majority of UK media coverage was anti-fluoridation reflecting what he believed was a general anti-establishment bias against health promotion messages amongst journalists and the success of the anti-fluoridation lobby in influencing the media.²²³ He also noted that with concerted effort it was possible for the pro-fluoridation lobby to reverse this bias.

Hastings *et al.* found that dental public health was not seen as great priority for the UK public and most people may not feel strongly about water fluoridation one way or another.²¹⁰ Their concern about dental health tended to be limited to the impact of appearance of poor teeth. Studies in Australia and the UK both found that the public found fluorosis aesthetically objectionable, and even considered that childhood fluorosis was an indicator of parental neglect.^{224 225} Hastings suggested that the public “will not rise up and demand fluoridation and do not feel sufficiently skilled to make final judgements on its efficacy”.²²⁶ Instead, anti-fluoridation lobbyists may be much more vocal. Dixon and Shackley showed that although the majority (62%) of UK respondents were in favour of fluoridation, the intensity of opposition of the 31% who were against was greater than the intensity of support of those in favour of the measure.²¹¹

Dixon and Shackley’s²¹¹ finding of a majority of their UK sample being in favour of fluoridation seems at odds with the response of our UK focus groups. But this may be due to the majority of people not holding strong views about dental public health, or an artefact of the way questions are asked, and the ability of people to develop and explain their opinions within qualitative research, compared with the *Yes/No* option originally presented by Dixon and Shackley.

The debate around fluoride has lasted for over 50 years.²²⁷ There remains uncertainty around the benefits and risks of fluoridation.²⁰² The debate remains polarised, although the apparent vehemence in the debate may reflect arguments between a relatively small number of lobbyists on either side. Holloway commented in 1977 that because the general public does not have a particular view on fluoridation “decision makers would have little guidance except for the activities of the pressure groups involved”.²²⁸ He suggested that both pro- and anti-fluoridation groups “*adopt similar strategies in that they communicate with those members of the community who are likely to influence decisions on water fluoridation*”, but that anti-fluoridation groups were more likely to use the media to influence the public directly.

Lobbying strategies do not seem to have changed significantly over time. Anti-fluoridation websites propose various claims about diseases caused by fluoride, although with the exception of fluorosis these have not been proven.²⁰² However, despite these relatively one sided messages, the European citizens within our focus groups have not reflected back the anti-fluoride rhetoric about morbidity, instead they been more concerned about the impact on civil liberties and water taste. Where they have raised concerns about harm, they tended to be non-specific and follow a precautionary principle.²²⁹ They preferred not to take any risks when benefits were ill-defined and, perhaps more importantly, where they recognised that better dental health could be achieved by the individual action of using fluoride

toothpaste/rinses/tablets. In such a climate, and with improving dental health in developed countries, it is unlikely that politicians will wish to tackle the opponents of fluoridation, even if they only represent a minority of the public, and require water fluoridation, despite its potential impact on health inequalities.²³⁰ Alternatively, governments, e.g. in the UK, have preferred to give responsibility for decisions about water fluoridation policy to others. Indeed, the tendency in Europe has been for artificial water fluoridation schemes to be removed rather than introduced.

7.6 Immunisation

This research found no clear correlations between attitudes to immunisation and gender, age, marital status or educational level. Focus group participants with children were slightly more likely to discuss immunisation and to hold stronger views on immunisation. This is likely to reflect their direct experience of thinking about vaccinating their children. The main differences in attitudes expressed in the focus groups were found at country level. Participants in countries where immunisation is compulsory were more supportive of State compulsion than those where immunisation is voluntary, and participants were more likely to discuss issues around vaccine safety in those countries where the intensity of vaccine scares had been greatest.

7.6.1 The concept of risk

The question on childhood immunisation was intended to be broad and to lead participants to debate whether parents should be free to decide the immunisation status of their children or whether the State should intervene and make childhood immunisation compulsory. The central theme emerging from the focus groups in numerous countries was the concept of risk phrased in terms of the pros and cons of immunisation. The question of parental choice versus State compulsion was often a secondary concern. The concept of risk was discussed in terms of both private interest – *“could immunisation harm my child?”* – and public interest – *“could non-immunisation harm other people?”*

7.6.2 Risk to the individual

A significant number of participants questioned the safety of immunisation and expressed concerns over the potential side-effects of vaccines, particularly the MMR. Where the risk of side-effects was perceived to be high, participants argued against immunisation and were generally opposed to compulsion. Where the risks of vaccination were deemed to be low, or were not even discussed, participants were more supportive of immunisation. Some believed that with adequate information and openness, parents would voluntarily choose to have their children immunised and thus compulsion would be both unnecessary and would undermine parental freedom to choose. Others believed that compulsion would be necessary to ensure that children were immunised, either because parents may otherwise forget, or because they may not believe that immunisation is necessary against certain diseases. Some participants argued in favour of immunisation on the grounds that they had been immunised against a range of diseases and had not been adversely affected. In contrast, other participants countered that they had been infected by various diseases in childhood and had not suffered any adverse consequences, thus immunisation against diseases such as measles, mumps and rubella were perceived to be unnecessary:

“MMR wasn’t about when we was kids, we all had measles, we all had mumps and German measles.”

UK/male/20-30/married/children/further education

Others recognised the continuing importance of immunisation, both to protect their own child against disease and to help protect other people.

7.6.3 Risk to other people

At the societal level there was broad agreement that immunisation programmes are beneficial to the public health. Participants praised the eradication of particular diseases (e.g. smallpox), and raised concerns that falling rates of immunisation could lead to epidemics of disease and the potential emergence of new strains of disease. On a number of occasions, public health was posited above the health of individual children. The majority of people who argued in favour of compulsory immunisation used public interest arguments as their justification. Although they may not be in favour of State intervention in other areas, they believed that compulsion may be necessary in order for herd immunity to be achieved and maintained and for the public health to be protected.

*“- Well, we are not crazy, but sometimes other people are crazy. You also have to contemplate other people who are not responsible enough for this.
- I think there are certain vaccines that should be compulsory, because some diseases could imply disease for others as well ... So not having this vaccine might affect third parties ...”*

Portugal/male/45-60/married/children/standard education

A number of participants demonstrated an awareness of the potential conflict between private and public interest in the sphere of immunisation. Individuals may not have wanted to have their own children immunised but they realised that if enough other people thought the same then the risk of epidemics would threaten the public health and this in turn would threaten the individual health of their children. This circular argument was picked up by a number of the participants who recognised the (potential) interplay of public and private health and interests.

“One mother is trying to save her child because she knows that there are unique features with regard to the vaccination. And the other mothers want the vaccination because they know that it’s a good thing overall, that it’s good for the general majority. So actually everyone’s going along the same lines”.

France/female/45-60/single/no children/further education

7.6.4 Differences in countries where compulsory immunisation already exists

In countries where certain childhood immunisations are already compulsory (Belgium, Greece, Italy and Poland), focus group participants tended to support the status quo, at least for those diseases which they perceived to be more serious. This obligation informed the debates, with some participants in the Polish focus groups querying why they were asked to comment on a law that already exists. On the whole, focus group participants (in each of those countries) supported compulsory immunisation, and hence the over-riding of parental choice.

*“- it is imposed by the doctor
- it is also imposed by the state because in order for a child to be enrolled at school vaccination is an essential condition
- there is legislation on this
- and it is good that it exists
- ... we have vaccinated our children through this system. The State has imposed this. So I can’t give any other answers. I say that we should do them.”*

Greece/male/45-60/married/children/further education

In countries where childhood immunisations are voluntary, focus group participants opposed compulsion and instead advocated their rights, as parents, to decide their child's immunisation status:

“Parents should have the power to decide, and parents have the responsibility as well”
Finland/male/20-30/married/children/further education

The most notable exception to this pattern occurred in the German focus groups. Although all vaccinations are voluntary in Germany, compulsory immunisation was advocated by a significant number of the participants. Their arguments echoed those from other countries: that health authorities and the state have better access to experts and information, that immunisation is generally in the best (private) interests of children, and that the achievement of herd immunity benefits public health and the public interest.

7.6.5 The foreign threat

Immigration was raised as an issue in a number of the topics discussed in the focus groups. In relation to immunisation, a small number of participants in Austria, Finland, France, Greece and Italy implied that certain vaccinations are or remain necessary because of the risk of disease entering the country through *foreigners*. Such participants tended to argue that immunisation would not be necessary in their respective countries if it wasn't for this *foreign threat*.

“The State has to promote it, because our State is becoming a multi-ethnic state. A lot of diseases totally unidentified are coming here in Italy and they are serious. There are tuberculosis and malaria in Milan. There are diseases that are kept hidden. That's why the State has to monitor, to make sure and, in these cases, to issue some regulations, issued by Regions. This is because unidentified diseases are arriving.”
Italy/male/45-60/married/children/further education

In some countries there was an underlying element of blame, while in other countries participants expressed empathy for those who were not fortunate enough to have had access to immunisation in their native countries.

“There are some things which are coming back. And why? Because there are things brought in by these groups of people who unfortunately didn't have access to these vaccinations, to that kind of healthcare”.
France/female/45-60/single/no children/further education

7.6.6 Trust

Whether directly or indirectly, issues of trust were raised in all countries. In Belgium, Denmark, Germany, Greece, Italy, the Netherlands, Poland, Spain and Sweden focus group participants expressed their trust in the immunisation advice of family doctors, paediatricians or state health agencies. The most common argument posited that doctors, health authorities or the State have better access to expert knowledge and the information with which to make immunisation decisions:

“It is outside of the decision-making competence of most parents. Sure, the situation is different if the parents are medical doctors, but this is probably a small percentage. This decision has to be taken away from parents, because they are simply not competent enough to decide.”

Germany/male/20-30/single/no children/standard education

Participants in one Swedish group developed their argument into a discussion of act versus omission – in this instance the potential harm caused to one’s child through the act of immunisation, versus the potential harm caused to one’s child if the parent omits to immunise and the child later contracts the disease. This led the majority of participants to advocate compulsory immunisation on the grounds that the decision should be taken by experts, not parents.

Where participants lacked confidence in the advice of their doctors, politicians or State health agencies, then they expressed greater concern over the safety of vaccines and were less inclined to have their own children immunised. This message was particularly strong with regard to MMR. For example, in two UK focus groups, the older and younger fathers referred to the fact that British Prime Minister Tony Blair had not disclosed whether or not his own young son had been given the MMR vaccine. This fuelled participants’ safety fears and jeopardised their faith in the vaccine:

“If the prime minister won’t let his own son have it then why should we put our faith in it with our kids?”

UK/male/20-30/married/children/further education

Some participants stated that they would like more access to information about the risks and benefits of immunisation versus non-immunisation so that they may make more informed decisions:

“I am taking the vaccination, but I don’t understand ... I have read a lot about these things and thought about them. I choose to take them, but I don’t think they give you any options, really. This is a good example of a situation where an independent party, whatever it might be, should inform people more”.

Finland/male/20-30/married/children/further education

However, participants in most countries seemed happy to rely on the advice of their family doctors.

7.6.7 Fears over vaccine-safety

Fears over the safety of vaccines were raised in a number of focus groups in Ireland, Italy and the UK. Participants made reference to cases and media reports where they believed that children had suffered from serious, and in some cases fatal, side-effects of the vaccination, and others stated their opposition to having their own children immunised:

“ Right, see, I was, I was for it, I let my son have the first one and then when it all came out and it was all basically, it came out it could cause this, it causes this, and my son is a very bright child. I absolutely flatly refused to let him have the booster, simply because if he’s come out like that I don’t want to spoil his intelligence by giving him something.”

UK/male/20-30/married/children/further education

Participants were divided in how they weighed the perceived risks. Some argued that the link with autism had not been proven and even if it existed the risk of developing autism from the vaccine would be less than the risks associated with contracting a vaccine-preventable disease. Others argued that, partly owing to the risk of side-effects, immunisation should be a matter of parental choice.

Focus group participants in Ireland and the UK expressed concern over the concept of *immune-overload*, both by questioning the safety of multiple vaccines, in particular the MMR triple-vaccine, and by discussing their perceptions of the relative merits of single antigen vaccines for measles, mumps and rubella:

“- It is 3 completely different injections and they are trying to put, trying to make it into one thing and that one chemical, whatever it is that they are using, and it’s wrong, it’s totally wrong.

- It should be available in 3 separate vaccines.

- I think there should be a choice.

- You should have the choice, I mean why do you have to pay for separate injections ... why should you have to pay for it when you, if one is free and one is not they are forcing some people into it.

- Right. So you are saying that single vaccines should be available?... That’s a compromise position?

- Yeah.”

UK/male/20-30/married/children/further education

In countries where the safety of the MMR vaccine was not debated (Germany, Finland), participants may have been unaware of the high-profile scare surrounding the vaccine or they had been successfully reassured by the State or relevant health agencies.

7.6.8 Discussion

Childhood immunisation is an effective means of eradicating or significantly reducing the prevalence of particular infectious diseases. However, in recent years rates of immunisation coverage have fallen, in some cases below the level required for herd immunity, thus raising the threat of outbreaks of vaccine-preventable diseases. One factor in this decline is the immunisation paradox, a phenomenon where the success of previous public health measures, mass immunisation and consequent herd immunity have reduced the prevalence of particular diseases leading parents to believe that the current threat of infection from such diseases is minimal. Some parents refuse to have their children immunised on the grounds that the risks associated with immunisation, though small, are perceived to outweigh the benefits.²³¹ Paradoxically, the success of immunisation programmes may ultimately reduce take-up rates with the potential for future epidemics of preventable diseases.^{232 233 234} A second factor in the decline of immunisation rates has been a number of recent vaccine scares.²³⁵ One of the most high profile scares, linking the measles, mumps and rubella (MMR) triple-vaccine with autism and bowel disease²³⁶ has an ongoing impact on immunisation uptake rates despite being shown to be groundless.^{237 238 239 240 241}

The State has an interest in encouraging immunisation, both to provide protection for individuals and to protect the public health via herd immunity. The regulation of immunisation varies across Europe. In the countries in this study, certain immunisations are

compulsory in Belgium, Greece, Italy and Poland, with non-compliance theoretically punishable by fines or temporary imprisonment for the parents and refusal of school enrolment for children. In other countries financial and non-financial incentives may exist to encourage parents to have their children immunised and/or to encourage health professionals to increase immunisation coverage.

A systematic review of qualitative studies looking at parental attitudes and beliefs toward immunisation found that in more than half of all the studies reviewed barriers to childhood immunisation included concerns over the risk of adverse side-effects, distrust of those advocating the vaccines, poor communication with health-care staff and a lack of awareness of the immunisation schedule.²⁴² Fears of side-effects and concerns over the safety of particular vaccines have been reported as factors associated with low immunisation coverage in numerous other studies^{243 244 245} and were common themes in the focus group discussions. Such fears need to be addressed by health professionals giving good quality information to parents and giving parents the opportunity to discuss their concerns around (particular) immunisations. Studies also suggest that parents fear overloading the child's immune system with multiple vaccines.^{246, 247} Discussions about *immune overload* within the focus groups were more prominent in countries where the MMR scare received a lot of negative media coverage and where immunisation rates have fallen, most notably in Ireland and the UK.

However, not all studies support the notion of a correlation between the health beliefs of parents and the immunisation status of their children.²⁴⁸ Instead, some studies report that immunisation status is more closely related to socio-demographic characteristics.²⁴⁹ A study from the Netherlands found that parents with the most negative attitudes to further expansion of the Dutch vaccination programme were more likely to be highly educated, health care workers, non religious, and to perceive vaccinations to be at best ineffective and at worst the cause of asthma and allergies.²⁵⁰ A study from the USA found that the parents of under-immunised children were more likely to be low earners, not have a consistent health care provider, to have four or more children, and to see vaccines as relatively unsafe.²⁵¹ This suggests that interventions may need to target particular socio-demographic groups. However, the only discernable socio-demographic difference in attitudes toward immunisation noted in the current study was that focus group participants who were also parents tended to have stronger views on immunisation. Whether this was an opinion for or against immunisation depended more upon the intensity of recent vaccine scares and trust in the reassurances of family doctors and State public health authorities. The other main pattern apparent in the focus groups was the correlation between support for State compulsion and the over-riding of parental choice amongst those countries where certain immunisations are already compulsory. This could suggest a degree of normalisation where laws on compulsory immunisation gradually become part of a cultural norm.

In some countries, a small number of participants spoke of the *foreign threat* whereby immunisation was deemed necessary to combat diseases being brought in from abroad. Where this *foreign threat* was raised as an issue, participants tended to refer to neighbouring countries. The Austrians and Finns spoke of the threat of disease entering from Russia, while the Greeks blamed the Albanians. However, this was very much a minority voice, with generally only one or two participants from each listed country making reference to a *foreign threat*. It is worth noting that the timing of the focus groups coincided with the global panic over Severe Acute Respiratory Syndrome (SARS), a disease spread between countries largely through foreign travel.

Access to information regarding immunisation was also raised in the focus groups. A number of participants commented that they would like to have more information, particularly around the MMR vaccine, in order to make an informed decision. This reflects findings from other studies, where parents who felt they did not have enough information were less confident in the safety of vaccines and had more negative attitudes toward their health care providers.²⁵² Such findings suggest that parental confidence in immunisation could be increased if trusted healthcare providers provide more information about the relative risks and benefits of immunisation versus non-immunisation.

A key finding in this study is the positive relationship between parental trust in health professionals and their decision to immunise. This finding has been supported by a German internet survey on parental attitudes to immunisation which found that 95.0% of respondents (5722 respondents) perceived their paediatrician as “*the most important source of information regarding immunization*”.^{246 253 254} This has significant implications for the role of physicians in increasing immunisation coverage. Studies from across Europe and the United States have shown that physicians who were concerned about the safety of particular vaccines were less likely to vaccinate or recommend certain vaccinations and this correlated with low levels of childhood immunisation.^{255 256 257} Similarly, parents within the focus groups who did not trust the advice of health professionals were less likely to consent to their children being immunised, particularly with the MMR vaccination. A UK study found that parents who were aware of the financial incentives offered to family doctors for reaching immunisation targets had less confidence in the recommendations of their health care providers²⁵⁸, however this issue of incentives was not raised in the focus groups.

In countries where the potential risks or side-effects, however small, of immunisation were not debated, one may assume that participants had no significant fears over the safety of vaccines and thus they trusted the advice of the State and any reassurances they had received following vaccine scares. By contrast, where participants spent most of their time debating the relative risks of immunisation versus non-immunisation or where they opposed immunisation on the grounds of safety concerns, then one may assume that participants lacked trust in the advice and reassurances of their governments and public health agencies.

In addition to a lack of parental trust in the efficacy of vaccines and/or in the health advice of governments or family doctors, other factors associated with low rates of immunisation may include the perception that building natural immunity to infectious diseases is preferable to immunisation and/or that vaccine-preventable diseases are not particularly serious.^{259 260} Each of these perceptions was raised in the focus group discussions. Ways of increasing immunisation coverage may therefore include improving physicians’ attitudes, beliefs and commitment toward immunisation^{261 262} and increasing parental confidence in the vaccines and in the assurances given by family doctors and the State.

7.7 Banning smoking in public places

All groups agreed that the government should encourage the public not to smoke. Additionally all groups were against a total ban as it was seen as attacking personal freedom and choice. There were mixed responses as to whether tax on tobacco products should be increased as respondents were aware the government benefit in terms of revenue. Most respondents supported banning advertisements and increasing health promotion, although they were concerned that these may be ineffective.

7.7.1 Smoking ban in public places

Focus group participants from all countries whether smokers or non-smokers, generally supported a ban on smoking in public places. Groups made mostly positive references to such bans in countries such as the USA, Ireland and Australia, although Singapore was used as an example of excessive regulation.

The main argument used to support a ban was that smoking *bothered* non-smokers.

“The problem with smoking is that you bother other people. That’s not fair.”

France/male/45-60/married/children/further education/non-smoker

Even most smokers agreed to some restrictions; however both smokers and non-smokers argued that smokers should be given a space in which they could smoke.

“You can’t force someone to tolerate your smoke, you should go to a special place to enjoy your cigarette”

Greece/male/20-30/single/no children/further education/non-smoker

Many smokers had mixed responses to whether laws should be used to restrict smoking as they were aware that this would restrict their own personal actions and choices.

“I mean I can definitely see the point of banning smoking in public places for the few. But with regard to society. No I don’t think that’s the sort of society we need to have. It’d be a society of restrictions.”

Denmark/female/20-30/single/no children/standard education/smoker

However, many smokers were supportive of regulation of their *habit* because they viewed smoking negatively and believed it would help them give up or at least reduce the amount of tobacco they consume.

“Society is trying to restrict me in some way but I’m allowing those restrictions to take place because I don’t think it’s a nice habit.”

UK/female/45-60/single/no children/further education/smoker

Smokers recognised the importance of respecting the private space of non-smokers.

“I’ve got my cousin there who’s strictly non-smoking, I don’t smoke in his house because it’s a matter of personal respect up to a point, I go outside to smoke my cigarette.”

Belgium/male/20-30/single/no children/standard education/smoker

However, many respondents expressed the view that people smoked in public places because of lack of education and respect, and regulation was required to enforce the social norms of respect and consideration.

“It’s because people no longer respect others that they have to legislate. Politics is nothing to do with cigarettes, it’s really stupid. It’s respect for the individual, for yourself and for others, we can discuss it all you like, but especially respect for others.”
Belgium/male/45-60/single/no children/further education/smoker

However it is clear that many of the non-smokers in the focus groups found it difficult to ask smokers not to smoke.

*“ -Yes but people don’t say anything. I don’t.
- No me neither. I mean I don’t know why actually. I mean you should really. But people just feel like... well no, they don’t want to.
- Why not?
- I don’t know, I guess people feel like they’re trespassing on someone’s property in a sense.”*
Denmark/male/20-30/married/children/standard education/non-smoker

It is possible that non-smokers supported regulations as a ban would remove the need for individuals to personally request people to stop smoking. It was observed by a few respondents that they had never been asked whether smoke bothered them, and as one noted:

“I am a non-smoker and I have to admit I have always regretted never having been asked by a smoker in public whether I tolerate he is smoking there now.”
Germany/male/45-60/married/children/further education/non-smoker

In many of the groups there was a feeling that smoking regulations should be enforced with greater penalties. This was seen especially in countries such as Italy and Greece.

7.7.2 Stigmatisation of smokers

Many of the groups spent time discussing how social attitudes and views of smoking impacted upon those who smoked in public places. In Ireland, most groups made reference to smoking being ‘socially unacceptable’. One man went as far as to describe it as an:

“Unsociable, dirty, filthy habit”
Ireland/male/45-60/married/children/standard education/non-smoker

In a British group there was mention of a *social leper*. A few smokers, particularly in Belgium saw the ban on smoking in public places in negative terms of *victimization and sanitation*.

“But let me come back to this issue of cigarettes. There’s fundamentalism involved, the word is not too strong. I’m a smoker; I can assure you I have been subjected to crypto-racist acts. And the law agrees. The law has done away with the three remaining seats in the train carriage where we could stop from time to time to have a smoke.”
Belgium/male/45-60/single/no children/further education/smoker

Some respondents saw this *fundamentalism* as mainly coming from ex-smokers. It has been noted that the smoking debate is highly moralistic, however the respondents indicate that this is also seen in public places where smokers are confronted by non-smokers.

“I think that this is part of that idea that you have the goodies on the one hand who don’t smoke and the baddies on the other that do smoke. (...) I can say that from personal experience as well as indirect experience, the more time goes by the more I see extremely harsh behaviour and comments towards smokers. It really is aggressive behaviour”.

Belgium/male/45-60/single/no children/further education/smoker

7.7.3 Defining a public space

One of the main concerns expressed in nearly all groups was the definition of a *public space*, which may mirror the problematic process policy encountered at the time in drawing up smoking regulation. Most respondents were aware in generality of where smoking was currently prohibited. For example they may know whether smoking was banned on trains in their country, but some were uncertain whether it was permitted at the train station.

All groups generally accepted non-smoking regulations in public areas such as schools, hospitals and public transport, which in many of the countries had already been established, even if not widely enforced. Some respondents saw pubs/bars, restaurants and clubs as different from public places as entering them was voluntary and one was not required to attend as a member of the public. Even most non-smoking groups seemed to hold or sympathise with this view (especially those in Ireland, the Netherlands, Finland and the UK). Thus, most of these groups concluded that non-smoking bans should be applied to those areas where individuals were required to attend (i.e. government buildings, schools).

In the case of restaurants even most smokers preferred non-smoking through out or a separate area for smokers. Some saw tobacco smoke as destroying the atmosphere connected with food.

“I mean, I go to have lunch, I go to a restaurant, I go there to spend a lot of money and then I find that bad ambience! I don’t smoke”

Italy/male/45-60/married/children/further education/non-smoker

However while most respondents preferred non-smoking restaurants they felt that the decision to ban smoking was up to the restaurant owner rather than the government.

Respondents saw a social connection between smoking and alcohol. Both smoking and non-smoking respondents argued that smoking had always been accepted in pubs/bars and thus should still be allowed.

“I don’t think it is necessary to overdo these things – and what is a public space anyway? A pub? People have always smoked in pubs”

Germany/female/45-60/single/no children/further education/non-smoker

Following on from the argument that smoking was an established practise in pubs/bars, some respondents expressed the view that someone in a pub/bar was already doing something unhealthy (drinking alcohol) and so should be allowed to smoke.

Generally it was felt that a ban would hurt the owners of social establishments rather than the smokers, and so pubs and cafés should use various technical solutions to accommodate non-smokers and smokers. Many of the groups expressed the view that the ‘bother’ smoke caused could be over come by such technical solutions.

“But then it’s the duty of that establishment to have a very good suction and really just taking good care that other people are really not bothered by it. That’s really an obligation of that pub.”

Netherlands/female/20-30/married/children/standard education/smoker

In some cases respondents suggested that the city planning should insure that there were a selection of non-smoking and smoking places.

There were some discussions as to the status of parks and (covered) bus stops. In these spaces there was an emphasis on being *basically outside*. Respondents generally felt that it should be down to a person’s own *common sense* rather than laws to modifying behaviour in these places. In many of the smoking groups there was concern that a ban on smoking in public places would stop them being able to smoke outside, and this was expressly discussed in a Spanish group where the streets were seen as being *owned by everyone* and thus smokers should have the right to smoke there.

7.7.4 Discussion

Smoking is the leading cause of preventable death in the European Union, killing over 650,000 people each year.²⁶³ The EU and national governments are discouraging smoking through a range of policies, aimed at both encouraging people to stop smoking and discouraging people from starting.^{264 265} One of the most successful policies is the regulation of smoking in public places, which both increases the effort required to smoke and de-normalises smoking.²⁶⁶ In 2002 the EU Commission adopted a non-binding Council Recommendation on the “*Prevention of Smoking and on Initiatives to Improve Tobacco Control*”²⁶⁷ although nearly all European Union Member States had some smoking restrictions regarding public transport and public buildings before that date. Restricting smoking in public places has already shown results in Europe. In Italy, for example, cigarette sales decreased by 8.9% after their ban.²⁶⁸

Public attitudes towards regulation of smoking in public spaces have been well documented in South Africa²⁶⁹, North America²⁷⁰, Australia²⁷¹, New Zealand²⁷² and Europe.^{273 274 275 276 277}

^{278 279} Differences between socio-economic demographics and between smokers and non-smokers have also been explored.^{280 281 282} However the majority of research has been based upon set interview questions and surveys. Little qualitative work has been done at the level of the general population in Europe to explore attitudes and beliefs in regard to smoking and the regulation of smoking in public places. It is critical for policies to be based, not only on benefits to public health, but also upon the attitudes and perceptions of whole populations especially when formulating acceptable, effective and enforceable regulations.

The analysis of the focus groups did not observe strong demographic variations between the perceptions and arguments of the focus group participants. Similarly non-smokers and smokers shared many values and views of smoking regulation in public places. This is

supported by a study in Australia which showed that over 70%, including almost half of smokers supported the establishment of some smoking restrictions in hotels.²⁸³

One reason for this may be the strong belief in *personal choice* expressed in nearly all the focus groups. Across all groups it was felt that it was a person's own choice to smoke, with references to *freedom of choice* and *personal choice*. This indicates the strength of the *individualisation* of health and responsibility for one's life and lifestyle choices.²⁸⁴ *Personal choice* was also at the heart of a non-smokers right to a non-smoking environment. However, the *right* of the non-smoker to clean air seemed to trump the rights of smokers. It is likely this connects with the image of the *considerate smoker* constructed by the pro-smoking lobby and now widely incorporated into smoking norms.²⁸⁵

The main argument used by the EU to support a smoking ban in public places has been the rights of workers to a non-smoking environment.²⁸⁶ While in principle regulating smoking in public places is supported by the general populations, the definition of a public space may influence attitudes. For example, while a UK survey found that 93% of the UK public supported smoking restrictions in public places, people differentiated between types of public spaces, with 88% of people supporting restrictions at work, 91% supporting restrictions in restaurants, but only 65% supporting restriction smoking in pubs.²⁸⁷ Similarly research conducted in New Zealand found that 85% of the general public supported a total workplace ban but only 56% did so when pubs were included as workplaces.²⁸⁸ In this study respondents only drew upon the right of a worker to a non-smoking environment in reference to their own personal workspace and did not apply it to restaurants, bars and clubs. In fact passive smoking and other health consequences of second-hand smoke were rarely referred to. This is unlikely to be due to lack of knowledge as an EU report found that 71% of Europeans believed that second-hand smoke can cause problems such as respiratory ailments or long-term illness.²⁷⁷

Social conventions were clearly important in drawing boundaries concerning where smoking should be tolerated. In the case of public spaces which were historically smoking areas (pubs/bars etc) smoking respondents seemed less willing to support restrictions and non-smokers were more willing for them to remain smoking. This is one of the few aspects of the focus group discussion where cultural specificity was seen, with references to smoking after dinner parties in Denmark and in Belgium's Cafés. A study in Australia has indicated that restaurant owners favour a ban on smoking in restaurants; however it is likely this will be influenced by the particular economic geography of the business.²⁸⁹ Similarly support for smoking bans in restaurants were associated with seeing smoking as unacceptable behaviour.²⁹⁰

In this study many of the non-smoking participants were reluctant to request a person to stop smoking. A 1992 European survey which asked people to rank on a scale of 1 (never) to 4 (often) how frequently a person would ask a smoker not to smoke, found that only 9% would often ask a smoker to stop. However, by 2002 this figure had increased to 13%.²⁷⁷

Overall adherences to smoking regulations in the EU have increased since 1995²⁷⁷. There are cultural differences in the respect for smoking regulation, with southern Europeans showing the least regard.²⁷⁷ It is clear that public opinion is crucial to the effectiveness of laws and regulations²⁹¹, in addition to this an individual's *moral commitment* to a law is tightly linked to whether they will obey the law.²⁹² Smoking restrictions have been widely accepted in those European countries that have already enforced bans, and this paper indicates strong

support throughout Europe. Concerns about *victimization* and *fundamentalism* expressed in these focus groups indicate the fine balance which needs to be struck when creating anti-smoking regulation to insure a minimal negative backlash. Governments need to create the environment to facilitate reductions in smoking in the population, to protect vulnerable groups, and to improve health and safety. However, attention also needs to be given to encourage continued dialogue between smokers and non-smokers, as non-smokers seem to be winning the argument based on the unpleasant nature of cigarette smoke rather than its effect on health.

7.8 *Not-in-My-Back-Yard: living near people with mental illness*

The phrase *home for people with mental illness* was variously interpreted by both moderators and participants to encompass the whole spectrum of mental illness, mental *handicap* and learning disability. In English, this variation means that at one end of the spectrum are psychopaths who need care in secure units and at the other end are dyslexics who need support in the academic environment. However, in some groups the term *mental illness* was used to encompass criminals such as sex offenders and paedophiles.

Understandably, the risks associated with different types of institutions for this huge range of potential *patients* varied greatly in the eyes of the participants – dyslexics or children with Down's syndrome were considered *safer* than sex offenders. Broadly speaking, the hierarchy of risk went as follows: secure units for child killers/sex offenders/paedophiles were the least desirable mental institutions, then secure units/psychiatric for other seriously mentally ill people (often described as *schizophrenics*), then open units/sheltered housing for people with mild mental illness, then homes for people with mental or learning disabilities with the physically disabled being viewed as the least risky. Overall, with the exception of the sex offenders, there was quite strong agreement that these people had to go somewhere, and they had a right to live in decent surroundings. In order to include the widest possible range of treatment centres, homes or secure units, in the analysis the overarching term *mental institution* has been employed here.

The discussions in the focus groups would be useful for exploring themes of prejudice and social stereotyping of the disabled or mentally ill, as so much of the debate focuses on what *mental illness* really means and how a mental institution patient / client really would behave. The debates and clarification needed by respondents were clear examples of strong particularism in this area. The particularism related to the different types of patients which would be treated in the institution, but also to the regime type, whether it was *open/closed* or *inpatient/out patient* or *hospital/home*.

“- They're going to put a centre for mentally disabled people that may pose a threat to the community. How would you react?

- Well, rather badly.

- Why might they pose a threat?

- Well because not everybody is fully in control of their faculties.

- It depends whether they've ever caused problems in the neighbourhood before”

Belgium/male/45-60/single/no children/further education/smokers

Consequently, while the question(s) asked in the groups provide a fascinating insight into different prejudices about mental illness or mental disability, as the respondents spent so much of the discussion establishing all the particulars and exploring hierarchies of risk, it is much less useful for exploring how people weigh up *public and private interests*.

Another significant issue in the groups was the strength of feelings the issue aroused. Participants often argued from a very personal perspective, and much of the discussion time in longer debates was one or two participants trying to *fight the prejudices* of other group members. Participants were often offended by the inclusion of mental disability under the banner of mental illness and by the stereotyped caricature of *schizophrenia* presented by the moderator or their peers. Where the “*home for people with mental illness*” was actually

presented as being a high security unit for criminal psychopaths and sex offenders this provoked much more emotive *NIMBY-ist* arguments than a home for disabled children. Indeed, in one group it provoked participants to criticise a group member as being *egotistic* because he was willing to accept such a high security unit in his neighbourhood:

- “- Well, it wouldn't bother me any more now, but when my children were born and I was young, back then it would have bothered me.*
 - Why?*
 - The concern for my children.*
 - But that would be a bit egoistic to say, now that my children have moved away, no problem. And the others, my neighbour's children, they don't matter as much, isn't it?*
 - No. I was asked whether it would bother me. I wasn't asked whether that would bother me on someone else's behalf, because I personally would not be bothered by it any more.”*
- Germany/male/45-60/married/children/further education

The mental institutions scenario was not discussed in great depth in the focus groups, but given the limitations of the data set this is of less significance than it would be elsewhere in the analysis. The limitations also mean that only the key themes to emerge across countries have been summarised, country-by-country analysis not being possible due to the various ways in which the question was presented and understood by participants both within and between different country groups.

7.8.1 Historical Context

In some countries participants looked at how the mentally ill or mentally disabled had been treated over the centuries in terms of exclusion rather than integration. However, the question had uncomfortable resonance for countries where in living memory the mentally disabled had not merely been excluded, but had been systematically murdered on eugenic grounds. Given this background, it is not surprising that some participants felt the entire line of questioning to be uncomfortable:

- “I am finding it problematic that we have to talk about this.”*
- Germany/female/45-60/single/further education

7.8.2 Conflating Illness and Disability

In some groups, participants sought clarification about the question, i.e. whether the patients in the proposed mental institution would have mental health problems or mental/learning disabilities. Most often it was the participants themselves who conflated the two and understood mental health problems to include mental disability, but where the moderator conflated the two issues, they ran the risk of offending the participants:

- “- I mean it's good for the sick to be taken care of, someone has to take care of them, right? But so it could be both sick people suffering from Downs syndrome or violent schizophrenics, or...”*
 - They're not sick, I don't like you saying that. The mentally disabled aren't sick.”*
- Denmark/female/45-60/married/children/further education

7.8.3 Mental Institutions as Risk-Free

For many participants, particularly in Austrian, Italian and Polish groups, the mental institution and its patients – either mentally disabled or mentally ill – were framed as risk free, so NIMBY issues were an irrelevance. Indeed, for some participants, where the question put to them related to a home for the disabled, not only was it viewed as risk-free, it was actually viewed as something very positive for the community as children should be exposed to a range of different people. Other respondents recalled their experience of working with handicapped people and the negative reactions of members of the public to these people. These narratives were employed in order to argue for a mental institution to be built in consultation with local communities and not simply imposed on them. However, with the mental institutions for people with mental illnesses, participants were more likely to view them as a bad influence on children.

Some respondents, particularly in the Netherlands, also joked that there were plenty of *strange* people in the city already, so it made little difference having a mental institution in their neighbourhood:

“Amsterdam is an open-air facility for the mentally disturbed (laughter). What are we talking about.”

Netherlands/male/45-60/single/no children/standard education

7.8.4 It Could Be Worse!

Where the mental institution was not deemed risk-free, it was often viewed as preferable to other institutions which could have been used. These institutions were considered less appealing because the people they would be dealing with would be in some way *riskier* than people with mental illness / disability. Sometimes these fears were not articulated, the comparisons were just presented in terms of preference:

“If you’d have said ‘for drug addicts’, then it would have been a different story.”

Netherlands/male/45-60/single/no children/standard education

“We have planning permission put in, in our road, somebody bought a big house and they wanted to convert it into a, it was going to be a hostel for asylum seekers.”

UK/male/45-60/married/children/further education

“I might have had a problem if there was a hospital for people with HIV”

Greece/female/20-30/married/children/standard education

7.8.5 It Could Be Me!

In many groups, a strong motivation for tolerance towards having a mental institution in the neighbourhood, was the feeling that mental illness or disability could affect anyone at any time. Other participants disclosed that people close to them were either mentally disabled or had mental health problems. Many participants, particularly in Belgium, Germany and the UK, argued that clients or patients at mental institutions were people who had rights and a place in society like anyone else.

The mental institution was most definitely seen as different to the *man made* risks from mobile phone masts or chemical factories, because there was a real human need for such

institutions, so the patients / clients really did have to have a home somewhere and people were more important than profit. However, there was one participant who argued that having a chemical factory next door was preferable to having the mental institution, as it would help fewer people and not just those living locally who have taken on the risk:

“Well, you can’t completely compare it now can you, those two things, because with the, with that factory you help your environment ... because a whole lot of people can go work there ... with the madhouse, (laughter) you help, you help a lot less people. You help, you help, crazy people who aren’t necessarily also in your own immediate environment.”

Netherlands/female/20-30/single/no children/further education

Participants in most focus groups also often had personal experience of living near mental or similar institutions, and had no negative experiences, although some had more frightening experiences of living near people with mental health issues.

7.8.6 Appropriate Treatment

Some actively welcomed the closure of large mental hospitals and trying to reintegrate mentally ill people into society.

“- let’s suppose that, all at once, they build a home for people with mental illness in the area close to your house

- It wouldn’t bother me

- Neither would I ... On condition that they aren’t any concentration camps, as they were before. Let them be real nursing homes”

Italy/female/45-60/married/children/further education

However, ‘concern’ for the wellbeing of patients was also used as a smokescreen to argue against having a mental institution in the neighbourhood, where respondents, particularly in Greece, asserted that for the wellbeing of patients such homes should be built in the country side rather than city centres.

“I think that they can build a clinic not in an inhabited area that would also harm the patients but in a place where they would have quietness, their comfort, not be bothered from us the sane.”

Greece/male/45-60/married/children/further education

“Well, I also wouldn’t like to have them somewhere in my backyard but I understand that they aren’t totally degenerated but maybe they got some kind of depression and then they got mentally ill... anyway I think that it’s better for them to be somewhere close to nature than in a loud part of the city.”

Poland/male/20-30/married/children/standard education

7.8.7 Reflecting Social Stereotypes

While mental institutions for disabled people were broadly viewed as risk-free, some participants were concerned about other issues, such as the patients making strange noises or looking funny. For those institutions which were understood as being for mentally ill people, the main concern was also with potentially noisy patients, except in Poland, where concerns about noise were strongly linked to fears about personal security if the patients were to escape.

Although many respondents actively rejected stereotypes about people with mental illness being a significant risk to local individuals, and many responded with indignation when moderators insinuated that people with mental health problems were a risk, others in many groups and particularly in Poland, did accept these stereotypes wholeheartedly and felt the key problem was that mentally ill patients at liberty would be a real danger to people living locally, even if this was expressed in a jocular fashion:

“It is more favourable, because, however, a mental patient could kill one or two, but a factory would kill many more, wouldn’t it?”

Italy/male/20-30/single/no children/further education

In the Greek and Swedish focus groups many participants expressed very strong concerns about having a mental institution next door, largely because they simply did not trust their authorities to run such institutions according to the rules, so there were bound to be escapes and other risks to the local community from violent mental patients. It was therefore unsurprising that real NIMBY sentiments were most openly expressed in the Greek focus groups. With the Swedish participants it was clear that they had been strongly influenced by two murders in Sweden which happened two weeks before the focus groups were conducted, because these murders had been committed by people known to mental health services. A leading Swedish minister (Anna Lindh) was stabbed while shopping in a department store and then, hours later, in a separate incident a five-year-old child was stabbed to death at her playgroup, which was in the vicinity of a mental hospital.^{xviii} Participants themselves argued that these incidents had shaken their faith in the system:

“You have a fairly reduced faith right now in the psychiatric healthcare sector because it seems as if there are not many resources”

Sweden/male/20-30/married/children/further education

The lack of trust or faith in the system in Greece and Sweden stands in stark contrast to the Dutch focus groups where participants trusted the authorities not to put them at risk by choosing to site a mental institution in their neighbourhood. A similar sense of trust could also be detected in some of the UK focus groups, despite frequent references to media stories about schizophrenics refusing medication and knifing strangers.

7.8.8 Political Correctness

Reflecting social stereotypes was commonplace in the focus groups, which would indicate that participants were expressing themselves freely without fear of ‘looking bad’ among their peers. However, discriminating against mentally disabled children was something that did cause further discussion among participants, and those participants brave enough to actually share their fears or reflected social stereotypes faced strong censure from others in the group.

“- does it have to be near our house? I don’t know what to say, it will be difficult to decide

^{xviii} Story details available at: http://www.landbou.com/News24/World/News/0,,2-10-1462_1415098,00.html, the Swedish focus groups were conducted on the 29th and the 30th of September 2003, the murders described here occurred on 11th September 2003. For a description of the impact such cases have had in Sweden see Lars Bevanger (2004) “Swedish Psychiatry in the Dock” BBC News (19 January 2004) [online] <http://news.bbc.co.uk/1/hi/world/europe/3408957.stm>

- *it is racist to say that you don't want it?*
 - *these people don't belong to the margin of society, it is wrong to feel like that*
 Greece/male/20-30/single/no Children/standard education

7.8.9 Discussion

The questions about how focus group participants felt about plans to build a home for people with mental illness in their neighbourhood formed part of a larger discussion about *Not-In-My-Back-Yard* NIMBY issues, and trust in information provided by government and public agencies. In addition to asking about how the focus groups felt about building a home for people with mental illness in their neighbourhood, they were also asked similar questions about plans to build a mobile phone mast and a chemical plant making everyday items, like plastic or pharmaceuticals.

In a survey published in 1997, over two-thirds of the mental healthcare providers in England and Wales experienced local opposition to community mental health facilities in the previous 5 years.²⁹³ Most of the organisations also reported that the extent of opposition had increased over time. The Scottish Association for Mental Health, a voluntary sector organisation, recorded incidents of local opposition to community mental health projects in Scotland, which indicated a similar degree of resistance in Scotland.²⁹⁴

The differences in the way the term “*home for people with mental illness*” was understood between groups means that care must be taken when interpreting the analysis, and in particular when attempting to deduce any differences between countries.

Angermeyer *et al.*²⁹⁵ examined public's preference for social distance from people with schizophrenia. Social distance was assessed using a 5-point Likert scale for the extent someone was willing to have a social relationship with a person with a mentally ill person as a landlord, co-worker, neighbour, member of the same social circle, personal job broker, in-law or child care provider. Gender and educational status were not predictive of desire for social distance. There was an association with age: the older the respondent, the stronger the tendency to shun a person with mental illness. Beliefs about the aetiology of the mental illness and poor prognosis were also predictive. However the most important determinants of desire for social distance were perceptions of unpredictability of behaviour and dangerousness.

Angermeyer *et al.*²⁹⁶ also examined the association between desire of social distance and pity and with perceived need for help for people with mental illness. There was a positive association between perceived dependency and pity. However, there was also a positive correlation between perceived dependency and fear. Thus Angermeyer *et al.* concluded that the effect of perceived dependency on other emotional reactions was contradictory and evoked mixed feelings, and could positively as well as negatively affect people's desire for social distance.

As part of a survey conducted in Germany on knowledge and attitudes about schizophrenia²⁹⁷, 7,246 people were asked during a telephone interview about their acceptance of a group home for 6-8 schizophrenia patients in their neighbourhood. 7.6% of interviewees would be supportive, 57.1% were indifferent, 30.7% would be worried and 4.6% would oppose the proposal. Of those 4.6% who opposed the plans, 53.8% said that they would try to prevent people from schizophrenia from moving into their neighbourhood. Anxiety and opposition

was highest among women and older age groups. Indeed women and older people also tended to display more anxiety about schizophrenia in other personal relationship and work contexts.

A survey conducted in Canada²⁹⁸ using similar methodology and questions also found that a majority (67.1%) of the 1653 respondents claimed to be indifferent about having a group home for 6-8 people with schizophrenia in their neighbourhood. However a larger minority of Canadian respondents were in favour (25.3%), with 7.6% opposed. Women were less likely to be indifferent than men (27.5% of women were in favour and 9.2% opposed). Logistic regression found that the oldest age group were almost three times more likely to express high social distance compared to their youngest counterparts. Those with the highest knowledge of schizophrenia were 10 times more likely to express highly tolerant attitudes, compared with those with the least amount of knowledge.

In both Germany²⁹⁷ and Canada²⁹⁸, a majority believed that people with schizophrenia could be successfully treated outside of hospital in the community (68.1% in Germany, 65.4% in Canada). Similarly only a minority thought that people with schizophrenia are dangerous to the public because of violent behaviour (18.2%, Germany; 14.4%, Canada) or are a public nuisance due to begging or odd behaviour (12.9%, Germany; 18.4% Canada). Both sets of authors speculated whether their findings may be subject to a social desirability bias, with respondents giving answers that they thought would be more politically correct, and hence concerns may be higher if there were actually plans for locating a home for people with schizophrenia within a respondent's neighbourhood.

However as Cowan has noted, there is a marked discrepancy between research studies on public attitudes to location of homes for people with mental illness and the experiences of organisations involved in consultation on, planning for and delivering community care.²⁹⁴ She suggested that this may be due to methodological limitations of such attitudinal studies such as the survey methods and attitude measurement scales used with hypothetical situations. Thus such studies fail to take into account the interactional complexity of attitudes expressed in real-life community care contexts and the way protagonists structure their arguments and rebuttals. Our European focus groups will also be limited by some of these methodological problems. Most notably, the scenario was hypothetical: the focus group participants were not being faced with a planning proposal for their own neighbourhood. However, the focus group methodology does allow debate and interchange of opinions between group members who hold different views.²⁹⁹ It also provides an opportunity for people to develop and explain their responses compared to a tick box or Likert type scale approach within quantitative research. Focus group participants may however feel reluctant to express views significantly different from the norm due to perceived group pressure.

Cowan²⁹⁴ attempted to explore more real public attitudes to locating homes for people with mental illness in, by studying public responses to such a proposal in a town in Scotland. She examined public documents such as correspondence in the local newspaper, and also conducted focus groups and interviews with people who supported and opposed the proposal. Opponents of the scheme raised the following objections: lack of prior consultation with local people and secrecy; unsuitability of the project's location; and the type of residents who would live within the home. Opponents claimed that consultation would have provided more information about the scheme and hence allay public fears. However, the proposers of the scheme believed that calls for more consultation were really a means for attempting to veto the proposals. Opponents suggested that without the input of local residents, a location had

been selected in an area of “*vandalism and high volume pedestrian traffic*” that was not suitable for patients and other residents. This line of argument was also seen within our focus groups, when some group participants suggested that people with mental illness would be more suitably located in more rural areas.

Angermeyer *et al.*³⁰⁰ examined the relationship between familiarity with mental illness and attitudes towards people with schizophrenia and depression. Familiarity was categorised according to whether the respondent themselves; a member of their family; or a friend/co-worker/acquaintance has undergone psychiatric treatment; or whether they had no personal experience of mental illness. Familiarity with mental illness inversely predicted the perception of dangerousness of people with schizophrenia and to a lesser extent also inversely associated with fear and social distance. Familiarity also was also inversely associated with perceived dangerousness of and desire for social distance from people with major depression. On the whole participants within our focus groups who had some degree of familiarity with mental illness tended to be more positive about locating a home for people with mental illness in their neighbourhood.

Lauber *et al.*³⁰¹ also constructed a regression model examining factors influencing desire for social distance from mental illness using data collected in Switzerland. Four groups of predictor variables were found: the illness depicted (i.e. schizophrenia compared to depression); attitudes to general aspects of mental health; emotions towards those affected; and attitude toward consequences of mental illness. However, the regression model also found that survey respondents from the Italian-speaking part of Switzerland wanted greater social distance from the mentally ill.

Lauber *et al.*³⁰² examined associations between linguistic areas in Switzerland with public attitudes on restriction on mentally ill people (withdrawal of the driver’s licence, withdrawal of the right to vote and requirement to have an abortion). They found that living in the Italian or French part of Switzerland was a significant predictor of the acceptance of restrictions. Italian-speaking Swiss had stronger opinions than the French speaking but this was not significant.

7.9 Obeying Rules and Social Norms

In order to explore European Citizens attitudes to obeying rules and social norms, they were presented with a relatively trivial case asking them what they would do if came across a “*DO NOT WALK ON THE GRASS*” sign in a park.

The majority of participants expressed their behaviour as conforming to social conventions:

“I’m fairly law-abiding.”

France/female /45-60/single/no children/further education

Only a few individuals in Ireland expressed any desire to break rules on principle.

“You have to walk on the grass (laughter) Even if you go and put one foot on it”

Ireland/female/20-30/single/no children/further education

“- There’s obviously a reason for it like but.....

- But sometimes we don’t care do we? A lot of the times we don’t care. Just do it for the hell of it really”

Ireland/male/20-30/married/children/standard education

For the other participants their decision to walk or not across the grass was based on the likely consequence of breaking the rule,

“It’s actually the weight of the consequences of breaking that rule governing whether you break it or not”

Ireland/male/20-30/married/children/standard education

7.9.1 Judgment based on likely harm of action

In most focus groups the initial question was met with arguments concerning the perceived harm of walking across the grass, which on an individual level was seen as causing no or minimal harm:

“-The worms perhaps?

-Yeah, I was just gonna say...the little blades of grass”

Belgium/female/20-30/single/no children/standard education

As the discussion progressed participants argued that routine non-compliance by individuals could cause damage.

“Well, because if I were to walk over that grass, not once, but if I keep walking over it, the grass will be destroyed.”

Netherlands/male/45-60/single/no children/standard education

Participants were also aware that while individual action in itself caused little harm, the collective walking of a large number of people would cause destruction.

“If everybody thinks like that the grass will be destroyed...[there] won’t be any park left”

Austria/female/45-60/single/no children/further education

“You see a nice park right, and there’s a sign that says do not walk on the grass so if a fellow ignores that right, and starts to go across the grass right, another fellow follows suit right and in 6 weeks there’s a worn path across that’s why people don’t do it and that’s why people are asked not to do it. 99% of people I think follow that.”

Ireland/Male/45-60/married/children/standard education

Many of the respondents felt that there must be a reason for such a sign, and often gave the example of a newly seeded area as a situation in which the sign would be required to minimise damage.

“Look, if I see a field that’s only just been seeded, then I can imagine that you can’t walk on it”.

Netherlands/female/20-30/single/no children/further education

7.9.2 Judgement based on function of grass

Participants also discussed the idea of harm in terms of the function of grass and the park. The grass in the park was seen as having a functional use; to walk on, play football etc.

“Grass is to walk on it. They should care for the grass to make it nice to walk on.”

Poland/female/45-60/single/no children/standard education

Parks were seen as public spaces which served an important role in people’s lives, and as such should be accessible,

“Is a park a green lung, or not? What is it for? For ‘pasturing’. So we can ‘pasture’ there without hesitation.”

Italy/male/20-30/married/children/standard education

Respondents who did not have a garden voiced the idea of the park as a space where they could enjoy grass, and argued that restrictions of accessing the grass were unreasonable.

“I felt like going on the grass. I haven’t got a garden. It’s a bit risky. We were beneath the trees. We felt good and also we weren’t the only ones, and when the park attendant came, we were thrown off, but I didn’t think this was reasonable, because I haven’t got a garden or a patio.”

France/female/45-60/married/children/standard education

Respondents who were parents argued that parks were there for their children to play in,

“- You know, if one of my kids wants to go to the park, I can hardly say “you can’t go on the grass”, that’s ridiculous

- Why is that ridiculous?

- Because, then they have to, then they have to put fences don’t they. I mean, a park is there to play in, final stop.”

Belgium/male/20-30/married/children/further education

Other respondents viewed parks as more formal spaces and argued for the preservation of the grass for aesthetic reasons and to attract tourists.

“One has to listen to the common sense, to see what is the smart thing to do and what is not. If there is a sign there will be a reason for it. The lawns are part of Vienna's beauty; the lawns are meant to be beautiful, not trampled down, as this attracts tourists who will say, it looks so beautiful.”

Austria/male/20-30/married/children/standard education

Some respondents observed that grass in the park was artificially laid out, and argued that their actions in the park would be different from in natural forest,

“Grass in the park, that is something that has been artificially laid out, but in the forest I behave differently”

Luxembourg/female/45-60/single/no children/further education

The artificial nature of the park was referred to by other respondents in terms of it being someone's work.

“Yes, grass that's only been seeded, then I also think, when they've been working on that, that I'll just, destroy someone's work or something.”

Netherlands/male/40-65/married/children/further education

The judgment of the grass as well maintained or not was used by some respondents to argue that they would obey the sign depending on the state of the grass,

“If there's someone who looks after it it's to respect his work, at least if it's a beautiful lawn anyhow. If it's a pretty lawn you're not going to walk on it, on the other hand if you see a half-bald lawn and everyone's walking over it then it's very easy to say I'm not going to take any notice either.”

France/male/20-30/single/no children/further education

The artificial nature of the park was also referred to in terms of respondents arguing that the designers of the park should have laid a path to ensure that if there was a reason to walk in a certain route it would not be across the grass. In this case respondents agreed that such signs were beneficial and that if there was need people could use the paths in the park.

“Yeah, that's good, that's good, yeah, it's good to have a sign cos, cos it's made, to make our life nicer, isn't it? If there was a reason to go through the park, they should just have a little road through it, a little path.”

Luxembourg/male/45-60/married/children/further education

Similarly there was the belief that if the grass was not to be walked on people should be given alternative spaces,

“It is good to have rules but you must also have an alternative solution, to have an alternative place for the dog to go and do his need for example - to have a proper park with a sign not to step on the grass, if the park is not a proper one.”

Greece/male/20-30/single/no children/standard education

7.9.3 Judgement based on being seen

Some respondents referred to the idea that there would be no consequence if you weren't seen.

"It won't hurt, not if you're by yourself and no-one knows about it."

Ireland/female/20-30/single/no children/standard education

Another respondent expanded on this by referring to pretending to be a good citizen,

"I wouldn't do it if someone was there or if someone was looking at me. No Jesus no I'd let on that I was a good citizen and take the long way round"

Ireland/female/20-30/single/no children/further education

One respondent referred to *being seen* in terms of setting an example.

"My job in life, I have to set an example".

Netherlands/male/ 40-65/married/children/further education

The importance of context and location was emphasized in another group which argued that their compliance depended upon the location. One Amsterdam participant argued that if they were in a quiet area of the city then they would be more likely to obey the sign.

"I think you know, where is the lawn. Are you putting this lawn in the middle of Amsterdam centre or ... say where it's quiet. There I wouldn't walk on the grass. Point one: everyone would see me. Point two: it's just quieter, you can go around it there, there are other facilities. In Amsterdam centre you're in a hurry, everyone's in a hurry..."

Netherlands/male/20-30/single/no children/standard education

7.9.4 Judgment based on punishment or fine

In comparison to the references to social norms and harm few respondents mentioned the issue of punishment or fines as a reason for not walking across the grass. One of the reasons for this may be that within the cultural context such signs are not taken as rules:

"Last summer, during the concerts, there were signs like that in Kaivopuisto, but I think they were only recommendations..."

Finland/male/20-30/single/no children/standard education

Generally people felt that such rule breaking went *unpunished*.

"You don't get strictly punished for disobeying that sign, and if you can save five minutes by stepping on the lawn, you do it."

Finland/male/20-30/single/no children/standard education

One respondent specifically referred to whether the sign was legally sanctioned,

"And that notice 'don't go', that all depends if it's got 'article this and that' underneath, so then you can get fined."

Netherlands/male/45-60/single/no children/standard education

In similarity with the idea of being seen, another respondent referred to the presence of the police as a reason why they may or may not walk over the grass,

“If I don’t see the police, I walk over it”

Netherlands/male/45-60/single/no children/standard education

However another Amsterdam respondent argued that the police in the city did not care about rules.

“In Amsterdam it doesn’t really matter all that much, you, you, you wave at the police whilst driving through a red light”

Netherlands/female/20-30/single/no children/further education

For many of the respondents the question of whether or not to walk across the grass was dependent on a number of different changeable factors (their mood, whether they were busy or late) rather than whether the rule was connected to a fine:

“I see my bus coming, I have to get there quickly, then I’ll think “oh fuck it, I’m just going over that grass”. And if I get caught and fined, well then I shouldn’t nag, then I’ll just pay it. And the moment that I’m not in a hurry or something like that, or I’m just thinking ‘it’s nice and easy’, then I won’t do it. Then I don’t think I’d do it”

Netherlands/male/20-30/single/no children/standard education

7.9.5 Judgement based on others behaviour

Respondents often argued that if others were walking across the grass they would also walk across it. Some also compared the harm caused by walking across the grass to others types of actions in the park which were seen as more harmful to the grass –and as a result their own rule breaking was not such a big deal.

“Young people do it. They play football. They play ball sports, although it’s not allowed.”

France/female/45-60/married/children/standard education

In this case respondents argued that more damage was caused by people making a mess on the grass and not cleaning up afterwards,

“It’s to avoid the grass getting wrecked. (...) it’s more to do with making a mess.”

France/male/20-30/single/no children/further education

Respondents also raised the issue of people sunbathing as causing more harm.

“No, but for me that’s the deciding factor. I’ve seen lawns that people have lain sunbathing on. They’re totally destroyed”

Sweden/male/20-30/married/children/further education

7.9.6 Judgment based living in society

Based on the idea that the park and its grass was maintained by someone, some respondents argued that those in charge would have placed the sign for a reason and that it was beneficial to the group/community to adhere to it.

“I think we have to live together in society, and that means that if there is a sign saying ‘Keep off the Grass’, there must be a reason for it, so I don’t walk over it.”

Luxemburg/female/20-30/married/children/further education

In other of the discussion there was a strong use of the idea of *respect*, and regulations were seen as part insuring they were maintained for the good of the community,

“Don’t walk on the grass, well I think that’s normal, after all are we not just respecting something that has been done for the good of the community?”

Belgium/male/45-60/single/no children/further education

Similarly a respondent noted that the rule stemmed from a government department having taken the responsibly to care for the grass

“I feel that when you pay taxes there’s some government department, some kind of organization that takes care of this. If they choose to put up a sign there’s generally some valid reason. Because, it’s once again, we want a functioning society and we don’t want to do it ourselves here, but we want someone else to it for us.”

Sweden/male/20-30/married/children/further education

It was also clear that for some participants the authority’s motivation for placing the sign on the grass was to saving money on cleaning up after people.

*“- I think it’s a question of good manners.
- That somebody doesn’t throw litter on the pavement for example.
- So what is it for?
- To save money.
- Yes.”*

Poland/female/45-60/single/standard education

7.9.7 Discussion

Social norms are one of the most central theoretical constructs in the social scientists.^{303 304} Norms are typically defined in terms of an obligation or social expectation which is backed by a non-legal sanction and are often the basis of more formal rules and regulations.³⁰⁵

Norms have been central to descriptions of how social order is maintained^{306 307} offering a basis for explaining cooperation between individuals and groups. Research within social psychology has shown that to explain individual and group behaviour one must take into account regulations and rules as well as social norms. The context of the situation is also important in the resulting behaviour, as the *activation* or *priming* of social norms by stimulus (such as an anti-littering signs) increase the likelihood of individuals complying with the norm (not littering).³⁰⁸

Carl Kallgren, Raymond Reno and Robert Cialdini have argued that a division should be drawn between descriptive norms (what is commonly done) and injunctive norms (what ought to be done).³⁰⁹ This section of the focus group discussion explored how individuals report both what they would do, and what ought to be done in regard to a sign in a park which says “*do not walk on the grass*”. There is likely to have been a wide variation in the acceptance of a sign stating “*do not walk on the grass*” as representing a social norm, a recommendation or a legally sanctioned regulation by the park’s authority. With this in mind the discussions raised a number of interesting items related to social norms. Rather the focus groups explored the deliberations surrounding its acceptance as a social norm, whether participants considered that the sign was correctly applied in the given situation as well how they justify their own reported behaviour within a group environment.

The major justification for the respondent’s behaviour was based on the likely consequence of disregarding the sign. Anti-littering research has indicated that the activation or *priming* of social norms has a clear impact upon behaviour. The results reported here indicate that not only were the respondents primed by the sign as to the state/health of the grass, but also to the grass as the outcome of the park keepers’ work and hence the impact of their action on others *work* and *efforts*. In this regard they were also highly conscious that it was not the consequence of their single action but the collective impact of many people walking on the same route which was likely to cause harm.

There has been much work concerning social norms and rule obeying is based on the idea that the individual involved rationally calculates the costs and benefits of breaking the law.³¹⁰ There are suggestions that an acceptance of a mild law (with only low cost) induces an expectation of cooperation, and that people tend to comply with the law if they expect many others to do.³¹¹ In this research we found that while a few respondents did mention the possibility of being fined, the possibility of being told off (or to move) and being seen to be breaking a social norm was more important. In addition respondents were aware that their own actions would be used by others to justify breaking the rule and lead greater harm to the grass and were willing to not break it to *set an example*.

7.10 Parental rights

A number of the questions asked within the focus groups explored views on parental rights; who is the *best judge*, and the role of the State, in particular discussion on issues such as immunisation, smacking, water fluoridation, religious refusal of blood transfusions and vegan diets.

7.10.1 Parental rights and *best judge*

In general, participants expressed the opinion that parents are the best judge of their children's best interests and that the State should only interfere in extreme cases where the child is potentially in danger. This belief was balanced against an acknowledgement of the responsibilities that parents have to their children. In certain situations, the state can be paternalistic and position itself as best judge. In the focus groups, such potential paternalism was often seen as an infringement of parental rights:

"- One of the pleasures of having made a baby is that, you've made a baby, and now you can bring him up into an adult, a citizen, to ensure they are well brought up. It's not about making a clone for the State and the State telling me what I should and shouldn't do."

France/male/45-60/married/children/further education

In all the issues discussed, the majority of participants asserted that in most cases parents should be free to make decisions about their children. For example, parental choice was often advocated above State compulsion in relation to immunisation:

"- I think you should choose for yourself whether you want your children vaccinated"

Denmark/female/45-60/married/children/further education/non-smokers

In discussions around raising a child on a vegan diet, many participants thought that State involvement was an infringement of parental rights. A number of participants expressed the view that vegan parents were probably better informed about their specific diet and nutrition than the government and hence were best judge, but some respondents felt that the State should intervene if the child's growth falls outside normal ranges:

"- Parents can decide what their children eat at home.

- In the child care centre they will see that the child grows and develops normally. They care for the child, at least, and if their growth does not develop along normal lines, they interfere."

Finland/female/45-60/married/children/further education/smokers

In situations where parents have refused to consent to life-saving treatment for their children on religious grounds, for example Jehovah's Witnesses refusal of a blood transfusion, the majority of respondents argued that, in such extreme cases, the parents' rights should be secondary to the child's rights, and the child's rights are advocated by the State in their concern over the *best interests* of the child:

"- I think that if it was dangerous for a child's life the court should decide that there should be a transfusion..."

Poland/male/20-30/married/children/standard education/smokers

7.10.2 State influence over parents

In many countries, the State attempts to influence good parenting by providing subsidies or incentives to encourage what it perceives as positive behaviours, and by punishing behaviours that it views as harmful. Focus group participants generally approved of State incentives to encourage *good* behaviour, preferring incentives to compulsion. For example, in discussions around the fluoridation of public water supplies, participants preferred that States provide subsidised fluoride pastes, tablets, and school dental health campaigns targeted at vulnerable children rather than introduce compulsory fluoridation and consequent blanket coverage for all. In many cases, they felt that mass water fluoridation was an infringement of their rights and not acceptable, even if it prevented dental problems in susceptible children:

“... Sure, fluoride would be good for the children, but it can be added to toothpaste and does not need to be tipped into our water.”

Germany/male/20-30/single/standard education/non-smoker

Similarly, in relation to immunisation, the majority of participants from countries where immunisation is voluntary argued in favour of parental choice rather than State compulsion. However, in countries where immunisation is already compulsory, participants (on the whole) tended to support compulsion and hence the over-riding of parental choice:

*“- it is also imposed by the state because in order for a child to be enrolled at school, vaccination is an essential condition
- there is legislation on this
- and it is good that it exists.”*

Greece/male/45-60/married/children/further education/non-smoker

7.10.3 The role of the State in a child's upbringing

Taking a *slippery slope* view, a number of focus group participants expressed their concern that State involvement in one area could be carried over into other areas, potentially leading to complete State control:

*“- The State wants to monitor everything. I don't necessarily agree.
- All that remains will be to make people wear a microchip”*

France/male/20-30/single/no children/standard education/smokers

For example, in relation to a ban on smacking children:

“- Today we forbid beating children and tomorrow we forbid cooking tomato soup...”

Poland/male/20-30/married/children/standard education/smokers

7.10.4 Role models

One of the arguments raised in favour of parental rights was that parents and other members of society have a responsibility to act as role models to children:

“- ...I think we’ve got a lot of responsibilities towards children and youngsters in our society...”

“- ...I think you can have a role model function towards youngsters...”

Belgium/female/45-60/married/children/further education/smokers

State laws also set guidelines for what is socially acceptable and help to set a good example to parents and, in turn, to their children. For example, a prohibition on smacking children was seen by some participants as setting a good example to parents and, as a result, in helping to instil the belief that violence towards children should not be used:

“- ... maybe it would make the public more aware. People hitting their children are well aware of the fact that they are not allowed to do that. So if it is made illegal, this doesn't really protect the child. But these people know they will be punished if it comes out in the open.”

Austria/female/20-30/single/no children/standard education/non-smokers

7.10.5 The greater good

Some respondents were aware that public health measures are about the *greater good* of the community rather than the individual and stated that they would be prepared to accept measures that would be beneficial for other members of society, even if they would not personally benefit. Similarly a number of participants argued that they were willing to give up some of their choices in order to protect the vulnerable. Such arguments were made in relation to water fluoridation, immunisation, and a ban on smacking children:

“- Isn’t it an interference in parents rights?”

- No.

- It’s important for the whole society”

Poland/male/20-30/single/no children/further education/smokers

“-I think it should be a law, this way we can save children who are really beaten”

Finland/female/45-60/married/children/further education/smokers

7.10.6 Trust

Issues of trust were raised around compulsory immunisation and the fluoridation of public water supplies. For instance some participants referred to fluoridation as mass-medication and questioned its safety and the potential side-effects of over-consumption. They did not completely trust the information they had been given by their politicians or experts employed by the government:

“- ... the person that gave the expert evidence in Australia, the first thing he did when they put fluoride in the water was invest in some kind of gadget to take the fluoride out of the water going into his house ... Who the hell do you believe?”

UK/male/45-60/married/children/further education/non-smokers

Participants were more likely to trust information if it came from a qualified source:

“- If a paediatrician tells me ‘Look, buy water with fluoride because it does [my child] good’ I will buy it for him”

Italy/male/20-30/married/children/standard education/smokers

With regard to immunisation, some respondents stated that they would be happy to accept the decision of State and relinquish their parental rights because they did not have the expertise to make the decision themselves:

“-The state should decide

- The parent but with the agreement of scientists

-What do parents know, what are they, doctors? ...”

Greece/male/45-60/married/children/further education/non-smokers

7.10.7 Enforcement

Participants expressed concern about the potential difficulties in enforcing some laws, for example a ban on smacking in the home:

“- and how are they going to check that? They will put a camera in the house?”

Greece/male/45-60/married/children/further education/non-smokers

Similar concerns were raised in relation to the difficulty of ensuring that a child of vegan parents has a balanced diet:

“-....They will have to introduce an obligatory check-up every other month in order to make sure that the child has not been given vegan food in the meantime...

- Such a law cannot be implemented.”

Germany/male/20-30/single/standard education/non-smokers

7.10.8 Discussion

This paper reports research involving a large number of focus groups over a range of public health policy areas. Parental rights were part of many policy issues discussed. In a democratic society, parents are in principle free to raise their children as they see fit. This makes practical as well as ideological sense in that it would be too expensive and time-consuming for the State to make all decisions relating to children. Having parental responsibility means that you have the right to make important decisions about your child's upbringing. It also means you have an obligation to care for the child, to act in their best interests and bring them up to become *good* citizens. However, the State has a role to play in ensuring that children are raised within the boundaries of social norms. It has an obligation to protect the interests of all its' citizens and to act via public policy to ensure that vulnerable groups are protected.

There are differences between countries as to the extent of such state intervention in parenthood. According to Millar and Warman³¹², European countries can be divided into three groups in this respect: intervention in only extreme circumstances; support for parents experiencing difficulties, and support for parenting with some recognition of the autonomy of children. Family policies, the state, the public sector, non governmental organisations, child welfare organisations and social work, have an important role to play in providing support and services. The state can intervene by offering incentives to encourage particular decisions by parents. For instance in some European countries, financial incentives (cash rewards, subsidised products) or non-financial (social or professional pressure) encourage child

immunisation.³¹³ Where parents do not make what the State believes is the right decision for their children it can compel parents to make particular decisions and punish them for non-compliance (with fines or imprisonment, etc).^{313 314} In other cases, the introduction of a law removes the autonomy of parents to make choices about child rearing, for example banning smacking, but the State also has a duty to intervene if children are put at risk of harm,³¹⁵ and can on some occasions override parents' wishes, for instance when parents refuse to consent to life saving blood transfusions for their child on religious grounds.³¹⁶

There was some concern that certain laws would be difficult to enforce, for example a ban on smacking, and could thus lose their credibility. However, the fact that the law exists sends out a normative message of what is deemed to be socially acceptable, and over time this could change attitudes and behaviour.³¹⁷

Trust in public health policy involves a variety of factors. The 2003 Eurobarometer,³¹⁸ undertaken by the European Commission, showed that only 10.7% of Europeans trust political parties as a source of information about health.. In the focus groups, there was evidence of public mistrust in the State, or the Public Health agencies acting on its behalf, particularly in countries where there are concerns over corruption or where there have been previous health scares for example mistrust of the measles, mumps and rubella (MMR) triple-vaccine following unfounded claims of an alleged link with autism and bowel disease.³¹⁹

Focus group participants felt that parents have rights in the upbringing of their children and that these should be respected. For instance they believed in principle that parents should retain the right to decide whether to immunise their children, or feed them a vegan diet, except in exceptional circumstances. Participants accepted State guidance over these issues although they did not completely trust it and expressed a desire to maintain a degree of independence in how they lived their lives and raised their children. Although in principle participants tended to believe that the State was generally acting in the public interest, some participants rejected such State interventions on the grounds that these interfered with individual choice and private interest.

7.11 Incentives and Enforcement

7.11.1 Preference for targeted incentives over enforcement

In most situations, a majority of focus group participants expressed a preference for incentives targeted at the relevant population rather than enforcement and blanket coverage for all. For example, when groups were asked whether they agreed that States should fluoridate the public water supply in order to improve the dental health of disadvantaged children, many participants suggested alternative, individual measures to help vulnerable groups while avoiding blanket coverage. Participants generally did not see an incentive for them to agree to have their water fluoridated and instead thought that dental health should be tackled in other ways that did not impact upon themselves. For example, they advocated targeted incentives in the form of State provision of subsidised fluoride toothpastes, rinses, tablets and so on, such that interventions were directed at people who needed them and the rest of the population would not be forced to drink fluoridated water:

“Instead of adding fluoride they could subsidise dentists more, couldn't they?”

Spain/male/45-60/married/children/standard education

Similarly, when groups were asked if they thought that smoking should be banned outright or banned in public places, most participants agreed that the government should encourage people to stop smoking but there was also clear support for respecting individual choice:

“If a law were passed, which would ban that I would feel patronised and that is against the democratic principles of our society.”

Germany/female/20-30/married/children/further education/smokers

There was concern that overly harsh restrictions would lead to a rebellion from smokers, while less extreme measures would receive greater support, help to set the framework for achieving the desired result, and could lead to cultural change and the denormalisation of smoking (particularly in public spaces). Thus participants spoke of providing incentives such as subsidised nicotine replacement products to help people quit smoking rather than removing individual choice completely:

“Bans always promote. They promote the desire, because you want to try the things you're not allowed to.”

Denmark/male/20-30/married/children/standard education/non-smokers

Where participants discussed immunisation in the context of parental choice versus State compulsion, the majority opinion was that immunisation should be a matter of parental choice. Some participants commented that if parents were given good, clear information then they would voluntarily choose to have their children immunised, thus compulsion would be unnecessary. Further, there was a belief that compelling parents to immunise could prove counter-productive as people do not like to have their freedom of choice removed:

“Here I'd say that I don't think they should legislate about things like vaccinations, I think they should give information. You can get a lot further. If you had received really good information then there probably wouldn't have been any doubt as to whether you'd let them go and be vaccinated. But if there's a penalty imposed – then you immediately get the other ... resistance towards it.”

Denmark/female/45-60/married/children/further education

In some groups and some situations, participants seemed amazed that either incentives or enforcement were necessary to make the public act in certain ways. For example, when the cash reward offered to parents in Austria who partook in a child health programme that included having their children fully immunised was reduced from €1200 to €200 (in 1995) immunisation coverage began to fall. This led a participant in one Austrian focus group to exclaim:

“We are discussing a matter of principle here. But what really scares me is the fact that ... there are health checks offered for children and some mothers did go when they were paid for... And as they might not get (paid) for it anymore today, they are just not going! And I do not understand that. I mean, does the State really have to pay me to make sure that my child is healthy?”

Austria/female/20-30/single/no children/standard education

The question of whether immunisation should be made compulsory also raised issues of trust as participants focused on their perceptions of vaccine safety and the risks of immunisation versus non-immunisation. Participants who trusted assurances from health professionals and the State that vaccines were safe were either happier to accept compulsory immunisation or believed that compulsion would not be necessary as parents would recognise that immunisation is in the best interests of the child. Those who did not trust public reassurances over vaccine safety were generally more concerned about immunisation and expressed a preference to make their own decisions about immunising their (hypothetical) children.

7.11.2 Social and professional pressure

Social and professional pressure can also influence attitudes, behaviour and adherence to public health policies. The incentives and enforcements associated with various public health policies make a statement about the social acceptability of certain choices and behaviours. In discussions over the pressure to have one's children immunised or to not smoke in public places, some participants commented upon the influence of social/peer pressure and pressure from health professionals or public health campaigns:

“And it is a common conversation topic to ask if your kid has already been vaccinated, it is a rule almost, an agreed deal.”

Finland/male/20-30/married/children/further education

7.11.3 The *greater good*

A number of focus group participants argued in favour of the greater good, stating that they would be prepared to accept compulsory immunisation, the fluoridation of public water supplies and/or a total ban on smoking for the greater good of society, and in particular for the greater good of disadvantaged populations and vulnerable groups, notably children. However, such sentiment was only expressed by a minority of participants; the majority spoke instead in favour of individual choice and of individual solutions (for example, the provision of better dental health services instead of mass fluoridation).

7.11.4 Preference for enforcement in certain areas

There were, however, some situations in which a majority of focus group participants who expressed a preference advocated legislation and enforcement. The issue of enforcement was particularly pressing when respondents spoke of vulnerable groups, for example in relation to prohibition of the sale of tobacco products to children and young people. In general, the health consequences to children and youth were seen as a valid reason for greater restrictions of freedom.

7.11.5 Enforcing the enforcements

In discussions around smacking and a total ban on smoking, focus group participants spoke of difficulties in the enforcement of certain laws. For example, irrespective of whether participants were in favour of a ban on smacking children, many expressed concern about the difficulty of enforcing such a ban in private spaces such as the home, and the concern that children, neighbours, or anybody with a grudge against the parents could accuse the parent of smacking the child out of spite:

“I’ve got something against my neighbour. Yeah exactly. I’ll report that he hits his kid”.
Belgium/female/45-60/married/children/further education

“There are certain areas where the state just can’t go any further, can the law go into the bedroom, into the house, how far can the law go, how can the state monitor that.”
Ireland/male/45-60/single/no children/further education

Thus, while participants may have viewed the end goal as desirable (for example, a reduction in the physical abuse of children, or fewer people smoking), there was some scepticism about the means of achieving those goals while trying to maintain a balance between public and private interest, responsibility and action.

7.11.6 Discussion

Public health policies are intended to promote and/or protect the health of (sections of) the population through encouraging socially positive behaviour and collective responsibility and discouraging or punishing negative behaviours. As such, they may involve incentives or punishments for acting or failing to act in certain, specified ways. Incentives may be financial (cash rewards, subsidised products) or non-financial (provision of food vouchers, social or professional pressure). They can be targeted at the individual patient/subject or towards the health care professional (for example, bonus payments for reaching particular targets). Incentives are used to encourage positive, healthy behaviours: for example, the provision of free or subsidised nicotine patches aims to help people quit smoking, free or subsidised fluoride tablets aim to improve dental health, and vaccinations free at the point of use aim to encourage immunisation and maintain herd immunity. By contrast, disincentives and punishments are used to discourage negative choices or unhealthy behaviours: for example, taxation on tobacco products aims to reduce tobacco consumption, and fines for failure to have one’s child fully immunised aim to encourage high levels of immunisation. However, providing financial rewards or incentives to individuals or to health care professionals is ethically problematic. Incentives have a disproportionate impact on lower socio-economic groups for whom the reward or incentive is relatively greater than for those in higher socio-economic groups; and the public perception that financial incentives to health care professionals may impact upon their professional judgment may affect public trust and the doctor-patient relationship.

Examples of State use of incentives and enforcements can be found in relation to policies on immunisation, smoking, fluoridation, smacking, and many others. The use of incentives and enforcements varies widely between policy areas and European countries, and raises a number of issues. Firstly, such measures may be ethically contentious in that they may infringe upon civil liberties or freedom of choice and they imply that the State (via the public health agencies acting on its behalf) is the best judge of what is in the public's interest. Although the State may have superior access to scientific and expert knowledge, issues around vested interests, individual choice and private interest must also be addressed. Secondly, particular laws and policies may be difficult to enforce. For example, while child health and immunisation records may mean that compulsory immunisation can be monitored, a ban on smacking children is difficult to enforce in private spaces, notably in the home. Thirdly, striking the balance between incentive and punishment can be problematic. For example, while an outright ban on smoking would be impossible to enforce and would likely lead to a rebellion, the banning of smoking in public places affects the normalisation and cultural acceptability of smoking and helps to reduce tobacco consumption. Public policy makers therefore need to produce policies that can be gradually accepted by the public whose health they are intended to promote and protect.

There has been limited recent research on public opinion relating to the use of incentives and enforcement in public health policy across Europe. This paper forms part of a study on the ethics of public health practice; it considers public opinion on tensions between private and public interest on a range of public health policy issues. One of the study's objectives was to provide information to give policy makers across Europe a better understanding of public opinion to population approaches to improving health, in particular in relation to reasons for supporting specific public health policies and their enforcement. This paper reports the findings in relation to public attitudes toward the use of incentives, enforcements, and concepts of the greater good and *best judge* in relation to policies on immunisation, smoking, fluoridation and smacking.

7.12 Trust

7.12.1 Who do the participants trust?

Participants did not totally trust the information they were given unless it came from health professionals or family doctors who they believed to have either their best interests or the interests of their community at heart. Some participants viewed the State (or agencies acting on its behalf) as having access to the experts and therefore better informed to make decisions. Regarding the safety of drinking artificially fluoridated water, some trusted advice from doctors:

“ -If a paediatrician tells me ‘Look, buy water with fluoride because it does [my child] good’ I will buy it for him”

Italy/male/20-30/married/children/standard education

When asked who they would trust, others said they would only trust someone they knew personally:

“- A researcher who is my friend...

-: ... and I just wanted to say, a scientist who knows all about radiation..., an independent scientist”

Austria/male/20-30/single/no children/further education

“- (...), Institutes, scientists.

- the institutes are also influenced by politics and money mainly”

Austria/male/20-30/married/children/standard education

Overall, participants tended to believe sources which were closer to home i.e. local over national, national over EU (this could also be because they are more familiar with them, not just because they are *closer*)

:

“- Local ones.

- Local ones, why's that?

- Because we trust them the most”

Denmark/male/45-60/married/children/standard education

7.12.2 Reasons expressed for trust in state or society or political system

Some participants expressed the belief that the state had their best interests at heart, and therefore could be trusted to do the best for them: (is this only in Sweden?)

“- The experts would have recommended it to us.

- They would have adopted a stance on the matter.

- Exactly

- And they wouldn't go ahead if they weren't sure it was for our own good.”

Sweden/male/45-60/married/children/standard education

“- ... A State run immunisation campaign can't ever be wrong can it?”

Sweden/male/45-60/married/children/further education

With regard to resistance to *risky* developments in their neighbourhood (NIMBY), such as the sitting of a mobile phone mast, a mental institution or a chemical factory, participants in Finland, Netherlands and Poland appear to have much more trust in the state to protect the population from unnecessary risk:

*“- If it were dangerous, they would not build it there.
- They would have found out already...
- I trust the Finnish society, no problem at all.”*
Finland/male/20-30/no children/standard education

7.12.3 Who did the participants distrust?

In the focus groups, there was evidence of public mistrust in the State or the Public Health agencies acting on its behalf, particularly in countries where there are concerns over corruption or where there have been previous health scares and scandals. In some countries the lack of trust appeared absolute and attitudes towards the state were often overtly cynical:

“- I wouldn't believe a politician, not at all!”
Austria/male/45-60/married/children/further education

*“- So what if state institutions said it is safe, would that be trustworthy?
- That definitely not at all.
- Why not?
- Because somehow at the moment trust in any state institutions is as low as ever.”*
Germany/female/20-30/children/further education

In general, participants did not trust the media:

*“- ...but journalists, you can't rely on them, they write this the one day, and that the other and...
- ...and they can be manipulated”*
Netherlands/male/45-60/single/no children/standard education

“- ...Well if you don't trust the government, then you shouldn't trust TV either...”
Netherlands/male/45-60/single/no children/standard education

Other participants did not trust the information because they were aware that the experts advice could be contraction by their actions:

“- Do you know that the person that gave the expert evidence in Australia, the first thing he did when they put fluoride in the water was invest in some kind of gadget to take the fluoride out of the water going into his house ... Who the hell do you believe?”
UK/male/45-60/married/children/further education

7.12.4 Reasons for distrust

Apart from a blanket distrust of politicians and media, caused by past events, a number of participants believed that due to conflicting interests, information given could not always be trusted:

“- I wouldn’t trust a public institution because I know that they would have other interests from that.”

Greece/female/20-30/married/children/standard education

“- It depends on who is conducting the investigation. If it is the industry itself, I am not sure I would believe it, because they want to sell their stuff.”

Germany/male/20-30/single/standard education

7.12.5 What type of information do the participants want?

Participants were asked if the thought it was acceptable for the government to withhold some information from the public in order to prevent panic and confusion. Some felt that all the information should be given uncensored:

*“- ...we are over-age, we want to know the truth.
-...we need that.”*

Austria/female/45-60/single/no children/further education

Others felt that there were situations where some information could be withheld if it could cause panic or not be understood:

*“- You should not scare people for no reason.
- They should give information up to a certain point. If there is a warning, ‘This might cause the growth of a sixth arm to your baby’... Not many people would want that product, even though there were ten good things listed there and only one ‘might’ at the end. It would scare people so badly they would not want to use the product.
- They should give us the facts”.*

Finland/female/45-60/married/children/further education

“- Not all the information can be given, some might cause alarm or terrorism, or things like that. They can’t go around and say what really happens, in my opinion. They must keep some information”.

Italy/female/20-30/single/no children/standard education

7.12.6 Discussion

Confidence in science and technology has eroded over recent years. Various health and food scares have impacted on the public’s general trust in government departments and raised new issues relating to trust in the science and technologies of food provision.³²⁰ The public’s reaction to scares such as Bovine Spongiform Encephalopathy (BSE)³²¹, the combined measles, mumps and rubella (MMR) vaccination³²² and the scandal of contaminated blood products in France³²³ have been taken as indications that the level of trust in national European institutions is critically low. In the case of BSE, European consumers have also lost faith in public health policies and in the scientists who sided with the government to dispel

public concerns about infected beef for purely economic reasons.³²⁴ Similarly there is a mistrust of the government handling of the MMR triple-vaccine in the UK following claims of an alleged link with autism and bowel disease³²⁵ which has since been disproved.^{326 327} This mistrust now extends to other areas and has already affected some technologies such as stem cell research and gene therapy.³²⁸ Cross-national comparisons of focus groups in several European countries reveal that distrust of scientists and regulatory authorities is a source of disquiet about GM food across Europe.³²⁹

Trust is by definition, particularly difficult to gauge, as it is a “*level of the subjective probability with which an agent will perform a particular action*” which occurs before the action can be monitored and affected by our own action.³³⁰ Trust in government policy and agencies is affected by a number of factors including the form of media coverage; a decrease in perceptions of impartiality of government agencies and experts; a perception that information has been hidden and that public safety is balanced against economic concerns.

As the focus group participants indicated greater weight is given to the opinions of people we know.³³¹ Trust in information sources are influenced by a number of factors, including where the information comes from, availability of alternative information and the perception of risks. While medical health professionals tend to be rated highly trusted, public health polices tend to be published by national government institutions. Trust in experts depends on an expectation that the experts will be technically competent and that they will hold other people’s interests above their own. Some level of trust ideally exists between individuals and experts (or institutions and organizations acting as experts). In a 2006 MORI poll in the UK, 92% of the public trusted doctors to tell the truth, only one in five adults trusted politicians and government ministers to do the same.³³² This agrees with results from the 2003 Eurobarometer, run by the European Commission which showed that on average only 23.4% of people had trust in their national government.³³³ In the focus groups, there was evidence of public mistrust in the State or the Public Health agencies acting on its behalf, particularly in countries where there are concerns over corruption or where there have been previous health scares and scandals. With regard to resistance to *risky* developments in their neighbourhood, such as the setting of a mobile phone mast or a mental institution, participants in Finland, Netherlands and Poland appear to have much more trust in the state to protect the population from unnecessary risk. In some other countries the lack of trust appeared absolute and attitudes towards the state were often overtly cynical.

The decrease in trust is a major concern for public health, particularly where it plays a critical role in the effectiveness and adherence to public health policies as well as enabling prevention programs (i.e. immunisations). In these focus groups most participants wished to have access to all the information so that they could make their own decisions and thought that this information should be provided by experts who were independent from economic interests. However they were also aware that such openness carried the potential that information may be misunderstood, cause unnecessary worry/panic and harm national security interests. Overall the participants accepted some censorship of information which they characterised as different from the State actively publicising misleading information.

7.13 Citizenship

The opening questions within the focus groups were in relation to participants understanding of community, and society and their rights and responsibilities.

7.13.1 What is community?

Most participants were able to easily identify with a notion of community – whether defining it as a geographical community (staircase, neighbourhood, district) or community of interest (work, hobby, religious) whereas society was more often viewed as an abstract – less tangible, concept.

Within the groups, questions on community and society were the first ones asked after introductions – participants were clearly feeling their way in many of the groups, with several groups simply coming up with lists of words to describe *community*, that were remarkably similar across different places and countries: Family; Work; Parish; Voluntary work; Sports; Friends, and somewhat more surprisingly: small animals (pets). One of the Irish focus groups included “*prisoners*” in a concept of community, reflecting political history in that country. In some of the groups, the notion of community encompassed a broader notion of the municipality, whole country, and the European community itself. This latter may have arisen as a consequence of the focus of the project as had just been described by the moderator. More rarely, and mostly in the younger age groups, the notion of “*global community*” was raised.

“All people – all on the planet”

Sweden/female/20-30/married/children/standard education

A range of views were expressed that people belong to different communities simultaneously and at different times of their lives, exemplified by this quote:

“Let’s just say that life is a bit like a Russian doll. You have a really small community which generally speaking is the family unit, a really tangible community and then you have a community based around your life so a professional community or another type of community and then you get to the more artificial (layers), the most abstract community, and yet on a daily basis I feel like I’m from Liege, but the Walloons, the francophone...”

Belgium/male/45-60/single/no children/further education

Some respondents, particularly in the Nordic countries were even willing to include strangers into their notion of community with the example of people you may meet on the daily commute: who in some sense are sharing a communal activity. Others were less sympathetic to a notion of all-encompassing community, expressing the view that there are some communities in which you have limited choice about whether to belong such as the family, but in others –work colleagues, fellow commuters, it is possible to choose not to regard oneself as a member. The notion of choice – some element of self-determination, is valued across the groups and countries. However the generally held view is that whilst individuals would like to be autonomous, most people recognise that mutual co-operation and negotiation is important too:

“We need each other – from prehistoric times “And that means that there are some rules and some of them are written down and some of them are unwritten. And it’s a case of getting the best possible conditions together”

Denmark/female/20-30/single/no children/further education

Nevertheless, participants also recognise that not all communities are benign:

“Groups as well as individuals can be unhealthy – e.g. school communities: I can imagine that for some people, that it’s the group spirit that, for instance can have its effect at a very young age. I know people for instance who don’t feel good at school for instance”

Belgium/female/20-30/single/no children/standard education

Across the countries the idea that some communities are closed and do not mix outside was raised at various points and in various ways. Some views are expressed more tolerantly than others:

“It’s them and us. We say hi to them and the children play but there’s no... there just isn’t. And so whose fault is it?”

Denmark/male/45-60/single/no children/further education

In other groups anger is expressed at the notion that outsiders, including migrants from within the EU, but particularly asylum seekers and refugees, may receive preferential treatment in terms of housing or services – this belief is expressed in several countries, notably in England, and most particularly in one of the Italian groups:

“We pay 50 Euros a day for that riff-raff.”

Rome/female 45-60/married/children/further education

In this particular focus group, caution must be exercised when interpreting the results – part way though a pejorative exchange a participant reports that her husband was murdered by an immigrant, instantly closing down the expression of any alternative point of view. Thus the importance of local context needs to be emphasised – a specific experience in one case, and the heightened awareness of *extremist groups* and issues around asylum and refugee status as portrayed in the media in the other.

7.13.2 What is society?

Society, on the other hand is seen as an abstract concept, and in some groups, only in ideal terms.

“Well society is getting things done I think. The public - the public authorities, the municipalities, the state, and county – what I belong to.”

Denmark/male/45-60/married/children/standard education

And in more obviously ideological terms:

“France stands for individualism”

Male/20-30/single/no children/standard education

Which gave rise to this riposte, from an opposing political perspective:

“Actually no, there are loads of communities. Community spirit is extremely resistant – increasingly so (...) With immigration communities everywhere. So there are loads of communities in France either from a cultural or a social point of view”

France/male/20-30/single/no children/standard education

Of particular interest is the Polish groups, which were unlike virtually all the other groups in holding extremely negative views about the society they lived in: a poor society; corrupted; a rat race; narrow minded; unequal; greedy; individuals but no society; malicious. Because of the strength and similarity of views expressed that are not mirrored by any other country, it would be more useful to regard the Polish social and political context post-communism as a special case, worthy of further analysis.

7.13.3 Comparison of community in past and present

Respondents varied in response, but most, if not all, seemed to view the past as a rosier place, in which people were able to care for one another more than they are able to at present. Many respondents put this down to the faster pace of life in modern times – mobile phones, the Internet, hectic working lives. However, some people are ambivalent about newer technologies and their role in community

“Nowadays everybody is in a hectic rush and it’s not going to change because technology is developing more and more varieties. So you have the possibility to preserve community by email, telephone or whatever. Therefore I can keep community alive but meeting up is important too”

Austria/male/20-30/married/no children/further education

Fear was expressed that with a work-life balance that is tipped towards work, children are out of control, and both family and communities suffer as a consequence.

“- Like kids now, they’d curse at you in the street, kids of 12 years old cursing at you Jeez, I’d never have cursed when I was that age I wouldn’t have dared, I’d be terrified”

“- but they’re not getting social skills, they’re just getting presents. Nice food, nice clothes”

Ireland/ female/20-30/single/no children/further education

Some groups raised the issue that with more women in the workforce than in the past (whether this is an accurate perception or not) a fragmentation of communities has occurred – women being perceived as a kind of *social glue*.

Not all groups felt that communities were better in the past, even if they were closer knit:

“That’s going back community. The word community is very small, we’re a global society and the world is becoming very small”

Ireland/male/45-60/married/children/standard education

In contrast, for this group without close family links– notions of community cohesion become increasingly important as we age:

“As a society we no longer look after the elderly, as we become the older generation who is going to look after us because in times gone past it was always that you were looked after by the family but now I would think the majority of us would go into a home”

UK/female/45-60/single/no children/further education

7.13.4 Collective versus individual model of Society

One of the key research objectives was to evaluate preference for a collective versus individual model of society. In order to focus respondents, they were asked to respond to two descriptions of countries in which they could live:

Country 1: The government provides a high level of public services – education, health, pension and social care – but taxes are high to pay for them, and because the government makes decisions, there are some limitations on choice about education, health and social care. If someone had a high wage they would pay more and poorer people would pay less, but all would have the same provision.

Country 2: Taxes are low but people are expected to pay for insurance in case they become unemployed or ill and to make provision and social care when they are older. However because taxes are low they can make own choices about what sort of insurance/ pensions to buy etc. All would pay the same for a particular package but people could choose to pay more or less to tailor their package to their needs.

In all focus groups respondents immediately associated Country 1 and Country 2 with models that exist currently – namely the USA (and the UK for some, e.g. France) and Sweden, respectively. Association of Country 2 with the USA entailed considerable negatives and antipathy – this was particularly focussed on perceived harshness and injustice of healthcare provision.

7.13.5 Advantages of country 1

Despite differing preferences for one *country* compared to the other, perceptions of the advantages and disadvantages of each system were remarkably consistent across countries and across demographic groups. The main advantages of Country 1 were that everyone is taken care of and has the same opportunities and a more philosophical position that it suggests a more mature and caring society: The only difference that stands out is the marked likelihood of young people to cite *less hassle* as an advantage of Country 1.

“The government is present at all levels regarding family needs and everyone has the same opportunities.”

France/female/45-60/married/no children/further education

“More equality, human dignity. Everyone is entitled, even if not in a job. That’s important”.

Finland/female/20-30/single/no children/standard education

7.13.6 Disadvantages of Country 1

A lack of choice was commented on by all groups, but there was some suggestion that this was a greater affront to only a minority. Although lip-service was paid to this loss of choice (which was suggested in the moderator’s description of country 2) the more emotive

disadvantage hinged on a loss of motivation in the wider society to strive and the knock on effects of lack of vibrancy. This extended in most cases to the whole economic landscape, not just public provision. Young people across countries were more likely to express concern that choices would be made by government that were not in their own best interests. However, in most countries these younger groups were prepared to subsume their own interests for the greater good – although much less true in the UK and Ireland.

The majority were very concerned about abuse of the system, but the majority of those who favoured this model were able to rationalise that this had to be expected and accepted for the model to function. However concern over *spongers*, *scroungers* and *abusers* was very acute and a culture of dependency and endemic laziness were mentioned in all countries as very real dangers of this system. Again, countries who were most unequivocal about this model felt that abuse would be minimal as individuals can be trusted to play the system fairly – indeed in some countries, namely Denmark and Sweden, it was very hard to countenance that abuse of the system would actually take place.

“If you can prove it is their own fault, they would still get help, but less help (than the others) – but I wouldn’t allow them to starve.”

Austria/male/45-60/married/children/further education

While not articulated immediately, after some discussion the idea of a monopoly provider opened up issues of sub-optimal provision through complacency of the provider. A lack or loss of efficiency was anticipated with implications for quality of services provided, particularly by those who were more accepting of Country 2.

The experience of *government* as the provider in Spain, Portugal and Greece highlighted the risks of relying on a sole provider as the state has been seen to fail in providing such services. In countries just starting to grapple with issues such as future pensions provision and the inability of the state to maintain current levels of provision (e.g. Germany, France, Finland) the idea that the state might *fail* or even go bankrupt was not anticipated but the start of anxiety about the state as provider was evident.

“It depends on how the country is run. It may be run badly, like Spain where we have a problem with pensions.”

Spain/male/20-30/married/children/standard education

7.13.7 Advantages of country 2

In evaluating Country 2 there was some initial confusion over the description in some groups. Many assumed that some form of safety net was implicit (perhaps suggesting that complete self-reliance is an anathema to many) and responded accordingly.

The advantages of an individual model of society were principally the recognition of effort and reward for effort made. The knock-on effects in society at large were mentioned by all groups – promoting enterprise, entrepreneurship, activity, creativity, enthusiasm, hard work, and so on. In terms of public provision the advantage of this system was felt to be efficiency and competition leading to greater choice and ultimately improved standards of public provision (although some could see that a monopoly provider may well become more of an expert than disparate, independent providers might).

At a more societal level many, but not all, groups could recognise that the need for individuals to make provision for themselves might foster a more pro-active attitude towards society within the population as a whole – the need to evaluate choices and involve yourself in the system could actually be to the good and other avenues like involvement in charity work would grow (mentioned particularly in the UK).

The minority who lean towards this system were all confident in their ability to prosper and play the system to maximum advantage to them (e.g. not paying for insurance in the certainty that they won't need to call on the services – particularly the young).

7.13.8 Disadvantages of country 2

The disadvantages attached to Country 2 were significantly harsher than those attached to Country 1 – and for people *repelled* by this system these disadvantages were completely untenable. The greatest disadvantage of a Country 2 system was the perpetuation of inequality. It was felt that the richer and more able groups in society would prosper at the expense of the poorer and less able groups, accessing more and better services. For many the effects on society would be profound – it places a value on wealth generation rather than intellectual or caring jobs and favours a particular set of (commercial) talents over others. The cycles of relative advantage and disadvantage set up through this would impact very quickly on life opportunities. The ultimate result of this kind of society was felt to be social unease, crime, anxiety and worry – one that few within the groups would wish to live in.

It was acknowledged that the system would be burdened by those who do not pay – either by design or by inability to take on this kind of responsibility. The needs of those who are not up to the challenge of managing their own affairs or understanding the system (through illness, learning difficulties, lack of aptitude, the elderly, etc.) would need to be taken care of and under this system many would *fall through the cracks* in the system and suffer. Allowing this perceived injustice was felt to signify a very uncaring society – going as far as being uncivilised for those countries and groups who supported a collective system most unequivocally.

“It is not acceptable that the foolish live in poverty. Not giving someone water in a desert is a crime”.

Finland/male/20-30/single/no children/standard education

“This is quite dangerous as there are lots of people out there who can't manage their money at all.”

Luxembourg/female/45-60/no children/further education,

“I quite like the idea of Country 1, I don't really mind paying taxes, if you're getting something back in return – I think it's the mark of a civilized government as well that we care for the weak and elderly and the poor and they definitely exist, there might be some people that are skivers and that is true but I do think we have to have something in place to look after the weaker ones of society.”

UK/female/45-60/single/no children/further education

“We should help everyone who needs help irrespective of whether they are deserving or blaggers.”

Denmark/male/45-60/children/standard education

“There’ll always be minorities like that in any country, and they may not all be foolish but just unlucky to lose their job or get a long-term illness, but whatever the reason, it is the government’s duty to help its fellow people. After all some might be in such situations because the state failed to educate them to save so it’s partly to blame!”

Greece/female/45-60/married/children/standard education

These views extend to people who may have brought harm on themselves (over-eating, drinking, smoking) as very few individuals wanted to judge or condemn

“We can’t draw the line like that, not if you are part of a community!”

Finland/male/45-60./single/no children/further education

Generally the majority felt that the foolish should be taken care of as well – based largely on the fear that *it could happen to me*. However, those who have not made provision for themselves (i.e. are experiencing hardship through their own fault) or whose lifestyles have contributed to the hardship should receive a more basic level of support. This is particularly true of opinion in Austria, Poland, Netherlands, Portugal and the UK.

7.13.9 Preference for country 1 or country 2

Overall the majority of the respondents involved in the study would prefer to live in country 1. Few, however, reason in *black and white* and for all but a few countries a mid-point appears most desirable and realistic. Even groups that expressed a preference for country 1 demonstrated a certain malaise or dissatisfaction with a *nanny state* – across many of the policy areas discussed.

Clear differences emerged across countries in terms of the nature of the response to these two models – country differences appeared stronger than differences between demographics within any one country. The key differences here hinge not only on the feeling that a collective model is morally *right* but in the belief in the viability and sustainability of this type of system. These countries are those that are already felt to provide higher levels of social provision and which appear to have least disparity in terms of wealth, education, opportunity, etc – namely Luxembourg, Netherlands, Denmark, Sweden, Finland, Netherlands and Belgium. In these countries probably no more than 1 individual in any group leaned towards a Country 2 model, in terms of having more choice.

“I can see that I would probably do better under Country 2, but other people in the population would struggle and so I would automatically choose to live in a country like country 1, not every one is going to cope.”

Netherlands/female/20-30/single/no children/further education

“If my personal freedom means there will be poor people who don’t think they can afford to pay out for cover, that isn’t right either.”

Austria/male/45-60/married/children/further education

Respondents appeared able, however, to countenance the idea of living in a Country 2 type system (with appropriate safety nets in place) and acknowledged that, although unattractive, this type of system is inevitable in the future of all developed countries (moving towards an American model). Countries in this group were Poland, Germany (with differences between old East and West), Spain, Italy, Portugal and Greece – all countries facing up to a future of

pensions crises and overstretched social services, i.e. a general need for greater self-reliance. The failing state provision of services in countries like Portugal and Greece meant that group participants felt pragmatically pushed away from Country 1 by this situation although from a purely moral and ideal point of Country 1 would be preferred.

A stronger leaning to Country 2 emerged among men and younger respondents. One similarity of these groups is that many were quite financially secure (or said they were) and felt that they would be able to take care of themselves under this system and they would not be paying for other people in society. These people were parents as well as non-parents. Many could identify that this is an attitude likely to be espoused by the young, and many older respondents felt that if they were young they would choose this path, but given their age and their needs in terms of provision of healthcare and pensions, etc, they could see that this system was no longer a real option for them. (This view was not only pragmatic, there were many examples of these older people also saying that the wisdom of age and understanding *what mattered in life* also contributed to them actually favouring a collective system at this point.)

“If I was younger I’d choose Country 2. I was born in Country 1, I can’t change to Country 2 now, I’m 60. You have to be realistic.”

Germany/male/45-60/married/children/standard education

“It’s great when you’re young but when the rust sets in and you start boiling oil that’s when the American system starts to hurt”

Ireland/male/45-60/single/no children/further education,

The UK and Ireland were countries in which the greatest number of individuals would choose the Country 2 model as a solution for *me and mine* above the future security of a collective model.

“I don’t have a private pension, that’s because that’s not important to me right now. I need to get money together to get a flat, that’s my main priority right now, so I can’t afford to put away. Now when I’m 80 I may be kicking myself...”

UK/female/20-30/single/no children/further education

It appears, from these groups, that the fact that the UK and Ireland are felt to be further down the path of self-reliance in this domain tends to make it a more acceptable reality – exacerbated by the perception in both countries that social provision (especially healthcare) through a taxation system is far from adequate.

7.13.10 Altruism versus self interest

In debating these questions there seemed to be a difference in approach, be it ever so nuanced. In the UK there appeared to be a correlation with right and left wing political views (which was more difficult to discern in other countries), and extremes of altruism and self-interest were evident in each of the groups. However, the majority of people ended up in the same place – i.e. wanting the greater good – but some appeared to get there through self-interest, in other words understanding *my interest is best served by a collective position, and fortuitously so is society’s*.

There was strong evidence that the majority across countries accept that they should pay for others. Respondents were asked about paying for the education and healthcare of others, even if they do not use these services themselves.

“I see the benefit for all – me paying for the education of others’ kids means when my mum gets sick, they will be paying for her.”

Austria/female/20-30/single/no children/standard education

“Maybe I won’t benefit from everything, but I’ll get some benefits...”

Poland/female/45-60/single/no children/further education

Accepting that an individual should pay towards others’ education appears to have a strong *moral* element, in other words education is very broadly perceived as an inalienable right for all, creating equal opportunity and contributing to [a better] society – particularly in Denmark, Finland, Sweden, Luxembourg, Austria and France.

The majority articulate that educating the younger generation is ultimately for the good and the prosperity of the country. Some go further in identifying that an educated population affects them by impacting on society and with improved lifestyle due to reduced crime rates.

In terms of healthcare, the majority were more emotive and tended to agree that it is right to pay for others’ healthcare more from a self-interest point of view – *‘it could happen to me/mine’*.

“Not everyone studies, but everyone becomes sick, it is a question of solidarity.”

Portugal/male/45-60/married/children/standard education

“It’s only fair to pay for those who have kids, as we might in turn contribute to other services we may not use/ need – imagine if they’re ill and I never am, I pay for them in a way, but that’s how it works!”

Greece/female/20-30/married/children/standard education

7.13.11 Rights and Responsibilities

Respondents were asked to spontaneously list rights/responsibilities. Similar rights and responsibilities were commonly mentioned across countries and demographic groups. A large number of other rights were listed. The most frequently mentioned rights (in order of frequency) were:

- Right to an education
- Right to healthcare
- Freedom of speech / thought
- Freedom of choice
- Right to vote/democracy
- Right to basic level of income/ pension / social benefits
- Justice/ civil rights/ right to protest
- Right to work/not work
- Personal safety/security
- Housing
- Freedom to practice religion

- Respect / dignity
- Enough food and basic life needs
- Right to free movement and travel
- Equality
- Right to life/die
- Freedom of association/ membership of trade union or political party

Many found it relatively easy to give examples of their *rights* but much more difficult to think of responsibilities:

“There are loads of duties, even though I could not think of any now.”

Finland/female/45-60/Children/standard education

“When we talked about duties we rather came up with rights.”

Austria/female/45-60/single/no children/further education

However, some groups in the Netherlands, Denmark, Germany and Poland found it easier to list responsibilities:

“Well, we’re responsible for our own lives, we have a responsibility towards society and toward our families. And then we have a responsibility to obey the law. And towards our fellow humans. And the responsibility is moral too, like keeping your promises and not demanding all the time”.

Denmark/male/45-60/married/children/standard education

In order of frequency, the duties spontaneously mentioned were:

- To have public spirit, civil courage, show solidarity and contribute to society
- To obey the law
- Pay tax
- Respect others
- To look after your family especially children (and insure that they are educated) and the elderly
- Behave responsibly
- Respect environment
- Look after your self
- To vote
- To work
- Military service

When challenged why they had produced a longer list of rights than responsibilities some groups suggested that this was just an artefact because the terms used for responsibilities were much more general:

“Maybe if it was written in a different way it will be the same ... because we wrote down respect . For example, I wrote them in a different way: observance of laws, respect for people.”

Italy/female/20-30/single/no children/standard education

Or actually if they spent time listing every law then the groups could have come up with far more responsibilities than rights:

“If we are talking about the duties of the Austrian or of any person who is here- we have an incredible amount of duties because we have a huge amount of regulations, you only have to take a look at the law, but we are not going to name all these now.”

Austria/male/20-30/single/no children/further education

A view was also expressed that you just get used to your responsibilities so you forget about them when asked to produce a list:

“There are loads of duties, even though I could not think of any now. I try to be a good citizen and do things according to the norms and laws.”

Finland/female/45-60/standard education/children

“We have a lot of responsibilities, but on the other hand we’re not always aware of them. I think that we have a bit of a tendency to sidestep responsibilities a bit, to maybe put the emphasis on our rights, ‘I have a right to this’ and so on.”

France/female/45-60/single/no children/further education

7.13.12 Role of the Media

Some blamed the media for the greater attention paid to rights rather than responsibilities:

“I think duties and responsibilities are completely sidelined and now through education and the media we’re only hearing about our rights.”

France/male/45-60/married/children/further education

“I think the media focus on [rights] all the time. You know if we think about what we read in the newspaper. People are, oh ‘I’m fighting for this, I’m fighting for that’.”

Ireland/female/20-30/single/no children/standard education

“The rights as opposed to the responsibilities are a sexy story.”

Ireland/male/45-60/single/no children/further education

7.13.13 Taxation in lieu of responsibility

In almost all countries, especially focus groups of young men, the idea of paying tax off-set the majority of responsibilities. In countries like Netherlands and Republic of Ireland there was much greater discussion around the idea of making a contribution to society by personal effort not just taxation. Germany, Austria, Spain, France and the UK were most likely to talk of paying taxes as fulfilling any obligation towards society. In Italy this was even stronger as paying taxes in a climate of evasion heightens their sense of entitlement.

One Italian man did not believe that he had any responsibilities at all:

“- what are your rights?”

- Education, health and national insurance, because I pay taxes. I have no responsibilities. I’ll explain to you why. I live in a country where I pay taxes, expensive, don’t I? Therefore I already pay for having education, health and national insurance”.

Italy/male/20-30/married/children/standard education

Other members of his focus group pointed out to him that he has a duty to pay taxes. However, he drew a distinction between services that he had to pay for and those that he did not. In the latter case, he conceded that there may be duties:

“I pay for services I have, they aren’t free. In that case, if they were free, I would have some responsibility. If you give me a free service, I will have some responsibility.”

Italy/male/20-30/married/children/standard education

Some group participants believed that the prevalent view that people discharged their social responsibilities through paying taxes could have negative consequences, if people no longer saw that they could make a personal difference:

“You pass the responsibility on to someone else in many things, like the environment issue for example. You think that you could not possibly make a difference because it is out of your hands.”

Finland/female/20-30/ no children/Further education

“I think that we don’t have enough responsibilities in a certain amount of situations ... I only have to throw a piece of paper on the street and there comes a garbage van to pick it up. I also don’t have to take any responsibility for my fellow citizens, because someone else will take care of them. I don’t think that’s right either ... I really miss personal responsibilities.”

Netherlands/female/45-60/married/children/further education

“We don’t emphasise the responsibilities that we have. We tend to get caught up on “the government says this” and then we wait. The citizen becomes like a child, waiting for the government to act. Each citizen should take themselves in hand and start contributing ideas, but for that to happen we need creativity to be something which is recognised in the debates. At the moment creativity is completely wasting away, we don’t use it, we’re not aware of it. We clip children’s wings when they go to school and then when they leave school we tell them ‘right, now you can go and be creative’. There’s a big gap.”

France/female/45-60/single/no children/further education

7.13.14 Responsibilities between generations

A number of younger groups talked of not having many responsibilities as they have not fully entered society yet – these were individuals and often students, specifically in Luxembourg and Ireland.

Young men with families, particularly in the UK, felt that their responsibilities extended to themselves and their families only.

“I think that your only responsibility is as a person is to look after yourself and your family.”

UK/male/20-30/married/children/further education

However, responsibilities to young and older generations was also a theme in other countries:

“It’s also about our children. Because children are our future. We hear about our responsibilities towards the elderly. Because they were sort of responsible for putting us where we are today. And elderly people also have responsibilities... towards young people. They have to look after us when we get old. Where old people actually looked after us when we were kids, you know.”

Denmark/female/20-30/single/no children/standard education

7.13.15 Enforcing rights and responsibilities

In France, most respondents (except women with children and no higher education) stressed the importance of the defence and fulfilment of their rights and showed themselves to be less aware of their responsibilities. Similarly in Ireland, younger women talked about defending your rights as a responsibility.

Polish groups also believed that it was difficult for them to enforce what rights that they had:

“We have a lot of rights but they aren’t respected.”

Poland/female/45-60/married/children/further education

People may have responsibilities, but this does not always mean that they fulfil these duties. This view was particularly common in Italy:

“- Italian people are moaners

- And do you think, as citizens, that actually all these duties are fulfilled?

- No!”

Italy/female 45-60/single/no children/standard education

It was suggested that the perceived breakdown in society was in part because responsibilities were not enforced:

“That’s why we’re in the state that we are today because too many people walk away from their responsibilities, there’s nothing to hold them to it.”

UK/female/45-60/married/children/standard education

People felt that there was a power imbalance with the State enforcing citizen responsibilities but not their rights.

“- Do you feel that we have strict punishments when breaking the law, here in Greece?

- If they concern the state yes, if they concern our rights no. If someone hurts me he won’t be punished, but if I hurt the State I will have very strict fines.”

Greece/female/20-30/married/children/standard education

“The question should be posed differently: ‘do you feel that they trample on your rights and that they put more responsibilities?’ I believe this would be a better question. We live in a state that obliges you to do things”

Greece/male/20-30/single/no children/further education

“I feel that I can not always make use of my rights, however I have to fully fulfil all duties”

Germany/female/45-60/single/no children/further education.

Partly it was an issue of clarity, in that obligations were more clearly specified, e.g. in law, compared to rights:

- “- I think that there are some rights, that we don’t know at all and they tell us about them only in some extreme situations for example advice of a lawyer in the social care.*
 - And I wanted to say that knowing our rights is our duty, for example if you don’t know them in our country, then they take advantage of you.*
 - OK, so you complain all the time that you don’t know your rights and do you accept your duties?*
 - We don’t have choice, generally...”*
- Poland/female/20-30/single/no children/standard education

A young man in one of the Belgium groups said that he was prepared to take on responsibilities provided that they were *discussable*. However, in general focus group participants felt that they were not consulted.

7.13.16 The appropriate balance between rights and responsibilities

An imbalance in favour of rights did not seem disconcerting to the groups, particularly in Austria, as they thought that having rights than responsibilities should be the norm in a liberal society:

- “In my opinion our rights are appropriate. Probably we have more rights because we are a very liberal country. This is why we have fewer duties, but still quite a lot of rights.”*
- Germany/male/20-30/single/standard education

- “Imagine if you had a whole lot more duties than rights, then you’d quickly end up in the direction of dictatorship”*
- Netherlands/male/45-60/single/no children/standard education

Most groups recognised that it was human nature to want rights rather than responsibilities:

- “We want too much, but we give less”*
- Italy/female 45-60/married/children/further education

- “We prefer to talk about the rights and not about that what we have to give to third persons.”*
- Poland/male/45-60/married/children/further education

- “You like it more when you get something than when you have to give.”*
- Belgium/female/20-30/single/no children/standard education

In Poland in particular, there was also a view that citizens had too many duties compared to rights. Although, with the transition from a Communist the balance was shifting:

- “We are changing our system to have more rights than obligations”.*
- Poland/male/20-30/single/no children/further education

Some thought that it was appropriate to have more responsibilities than rights:

“That is how it always is in a solidarity community. Fewer rights but more duties”
Germany/male/45-60/married/children/further education

In France it was felt that this state of affairs existed because people had abused their rights so much in the past

“I think that this framework exists because people have abused their rights too, and that out of necessity, responsibilities are there to limit everyone, because in the past, rights weighed heavier in the balance.”
France/male/20-30/single/no children/standard education

In Belgium and Scandinavia, an ideal society was felt to constantly re-evaluate the role of state and society.

There is some feeling that responsibilities are more oriented towards the personal or individual rather than society, with a loss of what is termed *civic courage* in Luxembourg, Netherlands and the rise of *me* or selfishness in Republic of Ireland.

Responsibilities were not always seen as being bad:

“There are pleasant and unpleasant duties. Paying taxes is certainly not a pleasant thing but being a patriot is a very pleasant thing and nobody should be ashamed of that.”
Poland/male/20-30/married/children/standard education

Indeed, some wanted more responsibilities:

“Maybe there are too few duties and responsibilities. They are not in balance in Finland. I am not convinced that it works if there are only a few responsibilities and a lot of rights.”
Finland/male/20-30/children/standard education

There was also a recognition that citizens should have responsibilities in order for society to function:

“I think that every country or society needs a certain amount of duties in order to make sure that everything works out...”
Austria/female/20-30/single/no children/standard education

*“- And if we didn’t have those limitations? If we were totally free?
- I think it would be worse than the Wild West”*
Poland/male/45-60/married/children/further education

7.13.17 The relationship between rights and responsibilities

There was a realisation in many groups that rights come with responsibilities:

“I think that to have rights you have to also take the responsibilities.”
Luxembourg/male/45-60/married/children/further education

"I am afraid that people only think of their rights nowadays, and forget about the duties and responsibilities. Rights and responsibilities go hand in hand, that is what I've been taught".

Finland/female/20-30/single/no children/further education

"But also they interact - what's my right is his responsibility. Or what's my responsibility could be his right."

Ireland/male/45-60/married/children/standard education

It was noted that it was important to act in the way that you would want others to behave towards you:

"Once you've agreed on some rights and then you stick to them...well then it's also your responsibility to apply them, both for you and for others. And that means you're responsible for making sure those rights are respected and that involves responsibility for particular things."

Denmark/female/20-30/single/no children/further education

It was also recognised that when living in a community, personal freedoms may have to be constrained if there were consequences for others:

"Everyone would like to have got freedom, but freedom will end when someone encroaches on other's freedom"

Italy/male/45-60/married/children/further education

"We're responsible that our freedoms don't interfere with other people's"

Ireland/female/20-30/single/no children/standard education

Some participants criticised those who wanted to isolate themselves from society and the associated duties as a citizen:

"We have a duty to do something ourselves...I mean to help society along so that it can help us in return you know. So you don't just sit in a cave somewhere and say - 'I'll look after myself thanks and I don't want anyone else helping me' - because people might want to do that sometimes. So even if you don't actually like other people, help them anyway. Making sure it all hangs together so you can get something back out of it yourself."

Denmark/male/20-30/married/children/standard education

However, rather than fulfil responsibilities out of a sense of solidarity, it seemed as though many participants discussed rights and responsibilities in terms of a social contract. If rights were not protected by the State and citizens did not get anything in return for upholding responsibilities, many people did not feel an obligation towards social duties.

"- It may be a vicious circle, because he says 'Why must I give anything if they offer me nothing?'"

- You don't give and they don't offer, if you don't give they won't offer you."

Italy/female/20-30/single/no children/standard education/non-smokers

7.13.18 Discussion

In a 1998 survey of adults in the UK³³⁴, aged 15 years and over, 50% of people surveyed said that they felt that they knew at least a fair amount about their rights as a citizen, compared to 65% who said knew their responsibilities as citizens (Table 2). Perceived knowledge about rights and responsibilities were lower among younger respondents to the survey (15-24 years old).³³⁵ Only 34% said that they knew at least a fair amount about their rights and 48% knew about their responsibilities as a citizen.

Table 2: How much if anything do you feel you know about your rights and responsibilities as a citizen?³³⁴

| | Your rights as a citizen | Your responsibilities as a citizen |
|------------------------|---------------------------------|---|
| | % | % |
| Great deal | 6 | 14 |
| Fair amount | 44 | 50 |
| Just a little | 37 | 28 |
| Hardly anything at all | 12 | 7 |
| Don't know | 1 | |

Virtually all people in the UK consider themselves to be a good citizen.³³⁴ On the whole they also consider other people living in Great Britain to be good citizens too (Table 3).

Table 3: Do you consider yourself and Britons as a whole to be good or bad citizens?³³⁴

| | Yourself | Britons |
|------------------------|-----------------|----------------|
| | % | % |
| Good citizen(s) | 95 | 67 |
| Bad citizen(s) | | 7 |
| Both good and bad | 4 | 24 |
| Don't know/ no opinion | 1 | 2 |

UK Citizens in the MORI survey³³⁴ were also asked which out of a list of traits were most important to being classed as a good citizen (Table 4).

The younger age group in the survey³³⁵ (15-24) felt the most important aspects of being a good citizen were respecting others (51%), looking after the environment (41%), obeying the law (40%), being a good parent (26%) setting a good example to others (23%), being a good neighbour (22%).

A more recent MORI survey³³⁵ conducted among schoolchildren (aged 11-16) in England and Wales, found that children were even more likely to say that respecting others (87%) and obeying the law (72%) were characteristics of a good citizen. The 11-16 year old children did not see the importance of good citizens voting at elections (6%), volunteering to do things (17%) and having a say in what goes on (19%).

In the 1998 MORI survey, the 15-24 year olds seemed to want to interact with society on an individualist level. They thought of citizenship in terms of how they should treat others and what they are entitled to. When asked about their rights, treatment by the NHS came first (69%) followed by access to higher and further education (64%) and unemployment benefit

(60%). Fewer put a premium on the right to vote or free assembly for peaceful meetings and demonstrations.

Table 4: Which two or three of these do you feel are most important to being a good citizen? ³³⁴

| | % |
|---|----|
| Respecting others | 41 |
| Being a good parent | 40 |
| Obedying the law | 39 |
| Looking after the environment you live in | 30 |
| Being a good neighbour | 30 |
| Setting a good example to others | 20 |
| Helping to reduce/preventing crime | 15 |
| Knowing your responsibilities as a citizen | 11 |
| Giving something back to your community/society | 10 |
| Paying taxes | 9 |
| Voting at elections | 9 |
| Having a say in what goes on | 8 |
| Improving your local area / community | 6 |
| Challenging the law when you think it is wrong | 6 |
| Being active in the community | 4 |
| Knowing your rights as a citizen | 4 |
| Volunteering to do things | 4 |

A considerable minority of 11-16 year olds³³⁵ (20%) felt it was not always wrong to burgle a house or steal from your family. Only 64% felt it was always wrong to carry a knife and only 50% felt that fare dodging was unacceptable.

In the 1998 MORI survey³³⁵, only 65% of 18-24 year olds felt that they “*belong strongly*” to their local community, compared to 74% of people surveyed aged 25 and over.

In another survey³³⁵ conducted in the UK by MORI in 2002 for the Commission for Racial Equality, only 1% of 16-24 year olds said that they felt a “*great deal*” involved in the local community, and 15% a “*fair amount*”, compared to 5% and 26% respectively for all adults. Young people were also less likely to feel that there was a great deal or a fair amount of community spirit in their area, compared with older people surveyed.

Many Focus Group participants paying tax in lieu of other social responsibilities. While arguably the burden of moral responsibilities is similar on all citizens across Europe, the tax burden on an average citizen varies considerably between Member States (Table 5).

Table 5: Income Tax and Social Security contributions (2006) within EuroPHEN Member States³³⁶

| Country | Income tax as % average wage for single person without children | Employee social security contributions as % average wage for single person without children | Total |
|----------------|---|---|-------|
| Austria | 11.5 | 14 | 25.5 |
| Belgium | 21.3 | 19.7 | 41 |
| Denmark | 30.1 | 10.6 | 40.7 |
| Finland | 19.3 | 5.5 | 24.8 |
| France | 10.9 | 9.5 | 20.4 |
| Germany | 17.5 | 18 | 35.5 |
| Greece | 6.8 | 12.5 | 19.3 |
| Ireland | 8.8 | 4.6 | 13.4 |
| Italy | 13.9 | 7.0 | 20.9 |
| Luxembourg | 12.3 | 12.3 | 24.6 |
| Netherlands | 11.7 | 19.7 | 31.4 |
| Poland | 5.3 | 21.4 | 26.7 |
| Portugal | 8.2 | 8.9 | 17.1 |
| Spain | 10.8 | 4.9 | 15.7 |
| Sweden | 18.2 | 5.3 | 23.5 |
| United Kingdom | 15.9 | 8.3 | 24.2 |

A Eurobarometer survey conducted in autumn of 2003³³⁷ looked at EU citizen's attitudes regarding citizenship and belonging. Out of a possible 14 options EU citizens were asked to choose 3 that were the most important to them in terms of their lives. On average across Europe, the most important aspect chosen was "*the family*" (82%). This was especially the case in Portugal, Greece, Denmark and Spain. Even in countries where this was a lower priority, it was still relatively high on the agenda, for example in the Netherlands (73%). Overall, health was the next highest chosen, followed by; "*work, friendship, a partner, money, education, spare time*", and "*religion*".

Eurobarometer participants were also asked to list three values of most importance out of a possible list of 14 (Table 6).

Table 6: How EU citizens rank values from a personal perspective

| Rank | Value | High | EU15 average | Low |
|-------------|--------------------------------|--------------------------------|---------------------|--|
| 1 | Peace | 66% Germany, 64% Italy | 60% | 51% Netherlands, 53% France |
| 2 | Respect for human life | 55% Italy, 54% Ireland | 46% | 36% Sweden, 38% Austria |
| 3 | Human rights | 57% Sweden, 46% Luxembourg | 37% | 26% Portugal, 27% Denmark |
| 4 | Individual freedom | 51% Austria, 44% Germany | 30% | 19% Greece, 20% Sweden |
| 5 | Democracy | 46% Sweden, 43% Denmark | 25% | 14% Finland, 19% UK |
| 6 | Tolerance | 31% Netherlands, 28% France | 19% | 0% Greece, 9% Italy |
| 7 | Equality | 26% Portugal, 24% Spain | 16% | 8% Germany, 14% Luxembourg |
| 8 | Rule of law | 33% Finland, 28% UK | 15% | 7% France, 8% Belgium, Luxembourg, Netherlands |
| 9 | Self-fulfilment | 21% Ireland, 19% France | 14% | 1% Denmark, 7% Italy |
| 10 | Solidarity, support for others | 24% Portugal, 23% France | 13% | 5% Ireland, 6% UK |
| 11 | Respect for other cultures | 24% Luxembourg, 10% Italy | 8% | 4% Finland, Austria |
| 12 | Religion | 30% Greece, 13% Portugal | 7% | 3% France, Sweden, Luxembourg |
| 13 | Don't know | 4% Luxembourg, 3% Austria | 1% | 0% Netherlands, Greece |
| 14 | None of these | 2% Austria, 1% Germany | 0% | 0% Finland, Greece |

The European Social Survey³³⁸ (the ESS) is a social survey designed to chart and explain the interaction between Europe's changing institutions and the attitudes, beliefs and behaviour patterns of its diverse populations. The survey covers 25 European countries, and is a data resource for researchers to conduct further analysis. As part of EuroPHEN (see appendix 3) the ESS dataset was analysed (using SPSS 12.0.2 for windows) to examine questions within the questionnaire relating to various attitudes and behaviour relating to rights and responsibilities of a citizen.

Most respondents thought that citizens should spend some free time helping others. However, there were significant differences between countries. For example, respondents in Portugal (88.4%), Ireland (88.4%), Spain (84.9%) and Greece (84.1%) were significantly more likely to strongly agree or agree with the statement than people surveyed in Netherlands (53.6%), Denmark (61.2%), Finland (63.6%) and Belgium (64.7%).

Conversely when ESS respondents were asked if “*society would be better off if everyone looked after themselves*” the French and the Belgians were most likely to agree strongly/agree. The Swedes were most likely to strongly disagree with that statement.

On the whole, ESS respondents thought that many people try to be fair, but only a few thought that most people in society try to be fair. In fact a minority of respondents said that most people tried to take advantage of them. Belief that most people tried to be fair was significantly higher in Denmark compared to other European countries. Within the EuroPHEN countries, a belief that people try to take advantage of each other was highest in Greece and Poland.

Similarly when asked about whether people could be trusted, The Danes were far more likely to say that most people could be trusted. The Poles and the Greeks were most likely to say that “*you can’t be too careful*”.

ESS respondents in Poland and Greece were also most likely to think that “*people mostly look out for themselves*”. The Irish were most likely to say that “*people mostly try to be helpful*”. As with other question about trust, respondents were most likely to choose answers which indicated that most of the time citizens tend to neither try to be helpful nor just look out for themselves.

Within the EuroPHEN countries, when asked “*if you want to make money, you can’t always act honestly*” the Greeks were most likely to agree and condone dishonesty. Belief in the reward of honesty was highest in Portugal, Denmark and Netherlands.

The French, Finns, Greeks and Portuguese were most likely to say that “*you should always obey the law even if it mean missing good opportunities*”. The Belgians and the Dutch were most likely to think that it was not always necessary to obey the law in order to get a good opportunity. Similarly when asked if it was “*occasionally alright to ignore law and do what you want*” the Belgians and the Dutch were most likely to agree strongly/agree.

Not cheating on taxes was seen as most important in Finland, Denmark and France. Once again, the Belgians were most likely to think it acceptable for citizens to cheat on taxes.

Women and older people were more likely to think that fellow citizens could be trusted, and that most people try to be fair and helpful. Women and older people were also more likely to think it important to obey the law, not cheat on taxes and to spend time helping others.

Throughout the countries surveyed there was usual a juxtaposition of both right and left wing political conceptions of citizenship and rights and responsibilities.

The right-wing interpretation suggests that there are fundamentally two types of citizens. Firstly, there are those who are willing to take responsibility for their lives, by working hard or gaining high qualifications and getting good job, paying taxes and being a burden to no-one. These are called “*active citizens*” by Keith Faulks.³³⁹ Secondly, there are “*passive citizens*” who (it is assumed) deliberately do not take responsibility by working hard and contributing to society through taxes and instead take advantage of state welfare systems, thus being a burden on other citizens. Usually those who argue this line of thought usually consider themselves to be the *active* citizens as well as other people that they know and that

others (usually outside their circle of acquaintances because they do not know any specific examples) are the *passive* citizens that cause all the problems in society by not taking responsibility but demanding their social rights. This is consistent, as Faulks says, with the logic of liberalism, which refuses to accept structural explanations for social problems and therefore condemns individuals for their own failings.

However people are not consistent in their stance and will change their tack, usually depending on their personal understanding/ prejudices of a particular situation. For example any sort of help for the elderly or children by the State is usually applauded, whereas helping people out of poverty who have got there by their *own fault* is not seen as morally justifiable. It is possible that politics on a national and international level also informs and influences citizen's understanding and opinions.

In the UK over the last 25 years of the Thatcher and Blair governments there has been a profound change in social attitudes and the perceptions of what a citizen is and their rights and responsibilities in relation to the State.

The Thatcherite governments tried to change the meaning of citizenship by defining the relationship between the state as guarantor of rights and the citizen as a recipient of those rights. Thus in the MORI survey conducted in the UK, but also in many of the EuroPHEN focus groups in other countries too, people talked about rights as something you get from the government as a consequence of paying taxes not something you get as just being a citizen. Within this right wing conception of rights and responsibilities, you had to be an active citizen, that is responsible for your own actions, yet at the same time be possessed of a sense of civic virtue, thereby the rigours of the market economy would be civilised by one's concern for local community and the country in general. It was felt that active citizens shared the same values and understood the need for reciprocal obligations and loyalties with very little need for the state. This allowed the State to be thinned-down, as it was seen by Thatcher and other neo-liberalists as intrusive, inefficient, and a break on the market economy that would bring prosperity to all. By bringing in service and market elements into public services, right wing governments across Europe during the 1980s succeeded in de-politicizing the government-citizen relationship: "*if your grandmother could not get a hip operation it was the hospital's fault, not the politician you had elected to office*".

As Faulks³³⁹ summarises: "*The Thatcherite years were marked by an approach to citizenship which attempted to reduce the universality of social rights, while at the same time expecting a universal sense of obligations.*"

From the right wing perspective, the problems of society were summarised as:

- Individual moral failure because of the overbearing *nanny state*
- The permissive society allowing people to rescind all personal responsibility and place it back with the state.

These perspectives were commonly presented within the EuroPHEN dataset.

The neo-liberalism of the Conservative and Christian Democrat years is of course not classical liberalism because it negates the egalitarian nature of the liberal ideal. The centre-left politics of Social Democrat parties of Europe that have dominated since the 1990s could be said to be more egalitarian, but still have market forces as a priority over the collectivist state.

There are many pressures in modern western society that are undermining the effectiveness of democracy and weakening traditional concepts of citizenship, a decline in the sense of community and solidarity among the public³⁴⁰, growing cynicism with politics and disaffection with political institutions^{341 342} a decline in institutions which underpin civil society and democracy such as political parties³⁴³ long term decline in electoral turnout in most mature democracies.³⁴⁴

State welfare systems are under unprecedented stress in all EU Member States. This is because of growing ageing populations and shrinking working populations paying into the pot, as well as growing demand for support from various groups. This has been described as a “*Fiscal crisis of the state*”³⁴⁵; that is increasing demands for spending on health, transport, education and pensions against declining ability of the state to deliver in the face of an increasing tax burden and therefore a tax-resistant electorate.

*At the heart of welfare policy is a social contract binding citizens to each other both contemporaneously and across the generations. This contract involves a willingness of some individuals and groups to make sacrifices in order to support others. If citizenship is weak then this social contract will also be weak and governments will not be able to deliver on their promises.*³⁴⁶

The growing burden of taxation limits the extension or creation of social rights. In fact it could be argued that there has been a deterioration of social rights within Europe as well as welfare rights. Pattie³⁴⁶ makes reference to Fraser and Gordon’s³⁴⁷ commentary on social citizenship in the United States where there is a strong tradition of civil rights. An emphasis on individual rights and sanctity of contracts has inhibited the development of social rights, so that even low wage earners have an anti-welfare mentality.

*The widespread fear that ‘welfare’ recipients are ‘getting something for nothing’ is an understandably embittered response from those who work hard and get little; their own paltry remuneration becomes their norm and they see themselves cheated by welfare clients rather than by their employers.*³⁴⁷

However, Pattie argues that rights are only part of the story as rights cannot be divorced from responsibilities and obligations, because as he points out, referring to the ancient Greek conception of citizenship: *To a significant extent one person’s rights are another person’s obligations.*

Pattie goes on to suggest a modern definition of citizenship: *A set of norms, values, and practices designed to solve collective action problems which involve the recognition by individuals that they have rights and obligations to each other if they wish to solve their problems.*

Pattie argues that the main goal of citizenship and therefore the State is common security. The goal of common security points out the fundamental dilemma of democratic citizenship; common security is defined by jointness of supply and impossibility of exclusion, as such there is always temptation not to contribute as your goal will always be met whether you contribute or not. Of course if everyone free-rides then there will be no security. This refers to game theory as portrayed in *the prisoner’s dilemma*.

Pattie quotes Axelrods^{348 349} solution to the problem:

1. *Individuals should not be short-sighted in their desire for payoffs. If people want instant gratification and are not prepared to wait for benefits to emerge then they are unlikely to cooperate and once again security will not be provided.*
2. *The game should be a repeat game, that is played many times over, illustrating the point that cooperation needs to be based on frequent interaction between actors. It may be rational to rob a stranger whom you will never meet again, but not to rob your neighbour whom you will expect to meet again quite often.*
3. *Individuals should be uncertain when the game will end – if they are not then the incentives to cooperate collapse.*
4. *Individuals should be able to sanction non-cooperative behaviour by punishing those who attempt to free-ride.*

Although, Pattie points out that the *solution* in the real world is often that cooperation is often enforced by state action, but then this assumes that the state will always provide the collective good.

Growth in Immigration and multiculturalism also has an impact on citizenship as populations in the industrialised world become less and less homogenous. In recent history the majority of people within a nation shared a common cultural identity and those that did not were generally ignored. Now as culturally distinct immigrant populations are asserting themselves and being taken notice of in terms of policy to varying degrees it is arguably much harder to engineer a social contract, when the nation no longer consists of a heterogeneous cultural majority.

The ability of a nation state to implement a social contract is also undermined by power being taken away from the state the increasing influence of global corporations, the consolidation of legislative power in supra-national bodies such as the EU. Also movements towards regional government, e.g. devolution in the UK, Flemish autonomy in Belgium, Catalan autonomy in Spain, Basque autonomy in France and Spain or Northern regional autonomy in Italy undermine the social cohesion that makes it easier to effect a social contract between citizen and the state.

The current poor state of the relationship between government and citizen has profound implications for those involved in public health and public health policy. In order for public health policy to be effective there has to be a dialogue with the public affected by it. The ability to have this discourse is limited by two main issues. Firstly the distancing by many governments from their political responsibility for services provided by state institutions by turning them into *agencies*, has radically changed the public's perception of these services. As politicians are seen as increasingly irrelevant, it is impossible for them to implement public health policy when they are seen as so distant from the very services they are trying to change/improve. Secondly appeals to people's civic duty to engage with government health promotion strategies, may have little impact when the very notion of citizenship is in such flux. Growth in multiculturalism and immigration, increasing influence of multinational corporations and supra-national organisations such as the European Union, movements towards devolution within the regions and therefore traditional citizenship, which relies on a sense of belonging to a nation, is undermined.

8 Understanding public attitudes to private interest / public interest tradeoffs –commentary on the Focus Group findings

8.1 *Paying taxes - safety nets for the unlucky, the foolish, and the selfish*

The most heated discussions between those devoted to the liberal tradition in some of its forms have always centred on to what extent the state can limit our freedom in order to avoid harm to others either by action or omission. In the Lockean spirit many are willing to argue that civil government should be based on the rights of individual human beings to protect their life, liberty and private property, the only inviolable moral law being that individuals are not allowed to interfere with the liberty of others if the liberty in question can be enjoyed by all.

Unfortunately those who stress the value of economic liberty and who speak for hands off policies often fail to see that the protection of so-called negative rights which they consider to be clear and simple is far from being so. It has been asked³⁵⁰ what these negative rights are, how can we recognize and define them and whether they possibly consist of only one such right, namely the right to liberty. And if negative rights should be reduced to a single right to liberty, are we able to define that liberty? The question arises when different liberties collide. A Nozickian kind of minimal state theory is particularly vulnerable to this criticism since he emphasizes, much more than his predecessors, the value of non-economic liberties.³⁵¹

But is it really possible that personal freedom finds its finest forms and expressions in a society where you can rely only on yourself in the provision of necessary means for life? What about the personal freedom and autonomy of those who, unlucky already at birth, are provided only with the barest means of survival? Economic liberty, if fiercely protected by the state, may create conditions where the only freedom left to some is to become marginalized and to choose between undesirable options. Lack of education guarantees in most cases a menial job, and lack of access to proper health care burdens life with unnecessary ailments and suffering. Although we cannot mechanically provide people with love and friendship, we can try give them access to commodities most of us value as necessary means for a decent life. Therefore, the classical Ayn Randian question why should I suffer for the bad luck of others, could – and I think *should* – be replaced with the question why should the unlucky ones suffer if we can help them without suffering ourselves? The presumption is that paying taxes cannot be seen as *suffering* by any right-minded person. Or are we ready to say that having to contribute to the well-being of others – or at least to the alleviation of potential ills – harms us to the point that traditional welfare state ideals of equality in need satisfaction should be simply abandoned? Can we truly value liberty if, at the same time, we are not prepared to adopt a single positive duty towards others? It is not enough simply to smugly remind those who demand help from others that many character traits, including apparent lack of self-sufficiency and lack of initiative to improve one's lot, are not necessarily self-chosen.

During the past years this traditional dispute *libertarians against welfare liberals* has reached new dimensions with the increasing popularity of conservative thinking. The question isn't merely whether to pay taxes to provide the less well-off with public services,

but rather whether publicly funded services should be restricted to cases where the needs are *genuine* in the sense that they are not self-inflicted, due to one's choices in life-style. The underlying (conservative) idea is that since some people seem to make wrong, irrational life-style and other choices, which could have been avoided, they should bear the consequences themselves instead of demanding that others should shoulder the expenses when things go wrong. These wrong choices may be wrong because they are seen as bad in the sense that they are *made by bad, immoral people* or they may supposedly be wrong choices made by not necessarily bad people as such, but ignorant and thoughtless egoists who burden the rest of the society through their lack of consideration. Obviously and at least according to John Kekes, in case of the afore-mentioned *bad* people, it wouldn't even be necessary to bar them from the use of scarce resources because the harm in question seems to be self-inflicted, but because in general they happen to be *bad* people. As he puts it: "*How could it be maintained that good and wicked people should be given the same amount of scarce resources? How could a system that is designed to ignore what people deserve be a system of justice?*"³⁵²

Kekes's presupposition seems to be that fair distribution of public services means that needs cannot be taken to be the only criterion for equal access, but instead individual merits and deserts should be decisive. What remains unclear is whether the "wicked" should be excluded because resources are scarce or because, in the case of abundance, bad people shouldn't be rewarded by others. If and when we choose the former interpretation, this kind of selection procedure is far from unproblematic. Firstly, in a pluralist, democratic society it would be difficult to reach a consensus on where the boundaries of wickedness lie. There might be some people most of us would with some ease call bad and some others good – at least till our *knowing* turns out to be sheer prejudice. Secondly, is it totally incomprehensible to claim that at least certain needs are such that common decency commands us to satisfy them, simply because of our shared humanity.

Most conservatives, including John Kekes, seem to think that all human needs and their satisfaction should be on one's own responsibility, at least if and when the person in need is not one of the *good people*. However, their way of seeing public services as rewards blinds them to the basic reasons and motives of those welfare liberalists who believe in need-based distributive justice. This misconception is detectable in the following quotation:

*"The assumption is that people are naturally good, and if they are not subject to unjust social arrangements, then they will live good rather than evil lives. The assumption is the liberal faith. It is from it that it follows that those who are worst off must have been unjustly treated; ...; that the distribution of resources should ignore moral merit because everybody would have moral merit if there were no injustice;...on a fundamental level everybody is equally deserving."*³⁵³

Kekes fails to see that people's moral worth shouldn't enter the picture at all if and when the original idea and decisive factor for helping others is their *need* for help and our ability to provide it. Most people want to live good lives and that is what a more or less ideal welfare state aims at, namely to provide its citizens with basic components for what they conceive to be a good life.

In what follows, the intention is to show that even though many people find demands for personal responsibility and moral worthiness intuitively appealing, they would lead to serious inequality among citizens. This would be the case not only in monetary terms but also in the

kind of life-style choices people are able to make because of their luck or misfortune since social background, genetic inheritance and the growth environment undeniably affect not only one's health but one's choices as well. Additionally, if the distinction self-inflicted / not self-inflicted or good versus bad behaviour were to be applied as criteria for distributive justice, we would end up with costly and bizarre practices. What would be the financial cost of all the detective work needed in order to discover whether somebody's need for help is self-inflicted by foolish behaviour or whether the allegedly foolish behaviour was voluntarily and autonomously chosen instead of being due to inherited and therefore not self-chosen stupidity. Or should we just leave it to the doctors who then decide according to their own impressions, prejudices and values?

We should keep in mind that if we are not ready to renounce our democratic ideals, a pluralistic and basically egalitarian society would be in difficulties deciding exactly *whose* views on foolish behaviour, unfounded and silly metaphysical beliefs or lack of understanding should form a basis strong enough to justify totalitarian strategies for distinguishing innocent, responsible citizens from reckless ones. Curiously enough, public debates clearly show that most of those people who want to draw a line between guilty and innocent behaviour, tend to focus only on certain types of self-inflicted harms, such as smoking, drinking and having sex – all activities traditionally associated with sinning, which even believers are usually willing to leave to the judgement of heaven.

8.1.1 Foolish behaviour – according to whom?

Should we be allowed to act foolishly? If foolish is given its lexical definition, then foolish behaviour means the person in question lacks a good sense of judgement, is silly and unwise. Therefore we might say that in many cases acting foolishly might also mean not acting prudentially, engaging in activities that may cause even serious harm - depending on the circumstances and whether a person is lucky or not. Foolish behaviour doesn't *necessarily* lead to any serious harm. It may have no consequences whatsoever. Walking against red lights may be sheer lunacy in heavy traffic but when there are absolutely no cars in sight and therefore little risk of being hit by one, it may feel a bit silly in waiting for the lights to change. And happily indulging oneself in seafood and other cholesterol-rich food may be foolish or even seriously harmful for those at high risk, while others do not even have to think about such matters.

In the Western tradition it would be difficult to show why acting foolishly could or should be forbidden if individual autonomy, in the Millian sense, is taken seriously and if we are not ready to adopt perfectionist policies where either some individuals or the majority vote are given authority over others' self-regarding choices and values. In fact, most of those who prefer one or other form of liberalism to strong paternalism and moralism³⁵⁴, are actually not saying they would want to legally ban all potentially self-harming behaviour. Rather, what they have in mind is that if people make foolish choices they should suffer the consequences and realise that the possible loss of life or limb simply just serves them right. Because of their foolishness, even recklessness, they do not deserve to have their suffering alleviated by measures financed by taxpayers' money.

This line of thought, however, is far from unproblematic. Why would it be of any importance *how* people have got their illnesses or injuries? If the basic principle behind welfare state policies is need satisfaction (avoidable death, curable illness or injury), it shouldn't matter *how* it came about, unless we want to reformulate this policy by saying that the idea behind

the welfare state should indeed be need satisfaction but only in cases where the need *hasn't been* self-inflicted. But were this reformulation adopted, it should be logistically and consistently applied to all services provided by the state no matter what the activities in question are, without making suspect *ad hoc* distinctions between acceptable and unacceptable risky behaviour. For some reason many people seem to be more than happy to classify certain choices as morally suspect and to include them among self-inflicted cases while considering some equally risky choices as perfectly valid. Division into *morally suspect self-inflicted* habit or practices and morally acceptable ones runs into the same difficulties as John Kekes's dichotomy "*good people vs. bad, wicked people*".

8.1.2 Not only foolish but bad as well

If all potentially self-harming activities were given equal weight so that people would be held responsible for their choices we would be living in a society where, for instance, the following scenarios could take place in cases where agents couldn't afford private services:

1. A is working hard to make ends meet. His doctor has warned him about endangering his health. A gets an ulcer. Since he didn't listen to his doctor, he will not be treated.
2. B went skiing and broke her leg. Since she knew this might happen, she will not be treated.
3. C and D were foolhardy and went sailing even though they were warned about stormy winds. Now they are missing and costly rescue teams are not sent to find them.
4. Against her doctors warnings E is pregnant again and knows that if there are serious complications, she will not be treated and she may well die.
5. F suffers from cerebral malaria. He will not be treated since he explicitly refused the use of prophylactics.

In all these cases people know that they run a risk of harming themselves but nonetheless they proceed with their original choices and plans. Now, someone might argue that even though what happens to these people is in a sense self-inflicted, these cases should be cared for since the activities in themselves are neutral or good innocent activities as such. Working hard is a Western virtue, skiing and sports are good for you, weather forecasts are known to be wrong, some religions do not approve of contraception, and people's fears about modern pharmacology should be respected. The advocate could continue by saying that people should be held responsible if the self-inflicted harms are caused by dangerous life-styles or reckless behaviour, which should be seen as morally suspect as such. Usually the hidden reason seems to be that such actions or life-styles are chosen in order to pursue of hedonistic pleasures. And, *traditionally* of course, hedonism is condemnable.

Now, would it be possible to find justifications for these additional distinctions? People shouldn't be assisted in their needs if the need in question is self-inflicted *and* foolish in the sense that either the activity in question is morally wrong as such, or it is wrong because it allegedly causes hedonistic pleasure. Would this distinction make it easy to justify helping the needy in these examples?

In example 1, A has been warned about the health risk he is taking with overwork. Working hard in order to make ends meet is not *usually* considered to be foolish or immoral. We might even say that financial hardship forces A to endanger his health, and therefore the ulcer he gets should in fact not be seen as a self-inflicted illness. But what if his financial hardship is

due to heavy gambling or an extravagant appetite for caviar and champagne beyond A's means? Would and should this information change the ruling?

Skiing is considered to be a healthy activity and especially suitable for women. As a physically demanding exercise it decreases the risk of frail bones caused by osteoporosis – nothing strange or foolish about that. But what if the injured skier B rejected the health value of cross-country skiing and instead opted for downhill and chose a slope meant for professionals, just in order to feel the thrill? For C and D going sailing in rough weather was a risky decision and luckily – in this example at least – we know that they knew about the risks and a lot of tax money was saved as because no rescue team was needed. Or then again, should they be saved after all since sailing is considered to be a civilised activity? But what if instead of C and D we had C2 and D2, who were rescued and we find out that not only did they know about the risk, but they also decided to sail while drunk, both of them bragging to their sailing pals that they are not cowards to be frightened off by a little storm? Should they reimburse the costs?

What about case E then? Most people would willingly admit that children give pleasure and most people do want to procreate. Does this make treatment acceptable? What if the woman in question didn't necessarily want any more children but couldn't avoid it since in her belief, God disapproves of contraception. Should we trust her life to her Saviour?

In order to make additional distinctions justifiable, one would have to show why some activities are morally suspect as such (not because they might be harmful to other people), have harmful consequences for oneself, why people shouldn't be helped if the harm they suffer may be self-inflicted and why hedonistic risky activities are worse than other risky behaviour. This might be a bit tricky because things are not always what they seem to be.

What if the hardworking man actually enjoys working hard? How do we know that the scientist who risks his health in the tropics isn't really enjoying himself hugely studying snakes, collecting butterflies and admiring the local ladies? Is the obsessive runner just keeping herself fit or actually doing it for endorphins? Is there really some meaningful difference between sports, drinking, smoking or stuffing oneself with cholesterol-rich and fattening food? If we are ready to say that people shouldn't be treated or saved or helped if they have knowingly endangered their lives then we cannot apply it just to smoking or drinking or other hedonistic pleasures unless we can somehow show that these practices are immoral and therefore should be both morally and legally banned altogether. At least people who indulge in them shouldn't be cared for if they get ill whether they go private or not.

The introduction of a Devlinian kind of a view on "*immorality as such*" into health care has at least two major flaws. Firstly, if people shouldn't be treated because of the immorality of their behaviour, because of the moral wrongness of it, then they should never be treated, not even when they could pay for it themselves. (Private hospitals might have difficulties in accepting this policy.) If it were to be applied only to those who need public health care then the general message would be that we have nothing against immorality if people can afford the consequences, moral acceptability being relative to one's financial status. To a proponent of the welfare state and equity this would be an absurd idea. On the other hand, for a conservative like John Kekes, this is exactly how things should be. In his book *Against Liberalism* he writes the following:

“The liberal intuition is that justice requires the recognition of the equal rights of human beings to the resources they need for living autonomously. The contrary intuition is that justice makes the right to such resources contingent on what their recipients deserve. The liberal intuition is motivated by the egalitarian belief that at a fundamental level all human beings have equal worth. The contrary intuition is motivated by the anti-egalitarian belief that the worth of human beings varies with their moral merits.”³⁵⁵

A year later, in his book *A Case for Conservatism*, he rephrases his anti-liberal views:

“Why should one think that when such basic benefits as security, health care, decent jobs or pleasant housing are scarce, then all people, regardless of their moral merits and demerits should get the same share of them? And why should malefactors, criminals and wicked people be as undeserving of the harms that they have merited by their way of life as those who have lived and acted decently?”³⁵⁶

But how does one create a ranking list? Who is to judge who is wicked enough not to deserve help? Is proper health care really to be seen as a reward for decent behaviour? Are doctors and nurses to become judges of wickedness? Unfortunately Kekes doesn't give us any criteria for telling the good and bad apart.

If the state's role were to be confined to taking care of the innocent, it would lead to rather extraordinary situations. In order to get public defence, the poor defendant should first go to court where it would be decided whether she is guilty or not guilty in order to know whether she deserves legal aid for her trial where it would be established whether she is guilty or not guilty.

If these innocent – guilty distinctions were to be applied to all possibly self-inflicted cases where we have reason to believe that one's distress may be self-inflicted, at least something resembling truth commissions should be immediately organised in order to find out whether people knew what they were doing. Since people are known to be less than honest when they have their own good at stake, this might turn out to be a long and difficult process. And of course, as in life in general, there would always be those individuals lucky enough not to need any public services no matter how foolishly they conducted their lives.

8.1.3 Selfishness – in what?

In this context selfishness cannot refer to one's reluctance to depart from one's money but instead the reasonable interpretation would be that the selfish ones are those who endanger their health without thinking about the other poor taxpayers. The underlying idea being that we have a duty not to cause expense to others. Up to a point it is a reasonable demand not to burden others in vain, but foolish behaviour is not a sufficient excuse for non-treatment. If this duty or command were to be taken seriously then it might also be our duty to avoid an extensive retirement period, not to mention the other costly risks involved in longevity. The model citizen would wish to have a heart attack the day he retires, thus maximizing his productiveness and minimizing the costs to society.

Is it reasonable to demand that people should avoid all risky behaviour because it could be seen as a form of unacceptable selfishness? Should we not be allowed to travel in exotic countries for fun because we might catch a costly disease? Should we instead reward those individuals who stay at home, away from harm's way and who claim to sacrifice their

eagerness to travel for the common good? Are they in reality just too lazy or frightened to leave their sofas and TVs? As long as we are willing to think that society should serve us and not vice versa, it would be difficult to convince people that one of their major duties is to live as cost efficiently as possible, avoiding pleasures some members of society might disapprove of.

If the concept and existence of public health care is accepted in general, then the only possible criterion for being treated is the patient's expected benefit from the treatment. All-encompassing access to health care can guarantee that even the selfish who are foolish enough to mistakenly believe in their eternal good luck get treated.

8.2 Self interested altruism

Increasingly autonomy is the dominant concept underpinning the codes of conduct for health professionals. Autonomy (*self rule*) is the capacity to think, decide, and act on the basis of such thought and decision freely and independently without hindrance. Autonomy is a more complex concept than purely respect for an individual's desires. For example Dworkin³⁵⁷ has suggested that autonomy is conceived of as a second-order capacity of persons to reflect upon their first-order preferences. Thus an individual may have a first order preference to smoke cigarettes but have higher-order preferences to remain healthy with a long life expectancy and hence have a second order preference for policies that assist smoking cessation.

Onora O'Neill³⁵⁸ has suggested that a plausible reason for the *triumph* of autonomy is that there is "*one presently prize domain of life in which informed consent requirements are often seen not only as necessary but also as sufficient for ethics justification*" namely consumer choice. The shift towards describing patients as consumers of health care has meant that attributes of the market have also been adopted. However, in addition to more cost-effective practices for the provision of health care, the market philosophy has also led to other consumerist thinking, with health care being seen as a transaction covered by a contract, rather than a social good aimed at improving health to facilitate social flourishing.

The balancing of rights and duties has been enshrined in the United Nations Universal Declaration of Human Rights (article 29) which indicated that the exercise of a person's rights and freedoms may be restricted for the purpose of meeting the "*just requirements of morality, public order and general welfare in a democratic society.*" Similarly, article 8 of the European Convention on Human Rights states that a public authority may interfere with the exercise of personal autonomy right if it is in "*the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health and morals, or for the protection of the rights and freedoms of others*". Thus, social control over an individual's reproductive autonomy may be legitimate if it is necessary to prevent harm to other individuals. As John Stuart Mill argued in his essay "*On Liberty*," freedom means "*doing as we like, subject to such consequences as may follow: without impediment from our fellow creatures, so long as what we do does not harm them nor attempt to deprive others of theirs, or impede their efforts to obtain it.*"³⁵⁹

Beauchamp and Childress recognised that as with all moral principles, the principle of autonomy "*has only prima facie standing*" and that if choices endanger the public health "*it may be justifiable to restrict exercises of autonomy severely*".³⁶⁰ The justification being competing moral principles such as beneficence or justice. However, this approach to bioethics analysis based on *principles* advocated by Beauchamp and Childress, among many others, has become an unequal battle, was an almost unrivalled pre-eminence of autonomy, despite attempts by Beauchamp and Childress to stress that this should not be the case.

Of course an individual could act altruistically in the interests of a third party, even though it is counter to their own interests. Alternatively, individuals may be motivated to act in the interests of others out of a sense of solidarity.

However, a consumerist approach to bioethics, and public health ethics in particular, cannot depend on making appeals to altruism or solidarity. A consumer is unlikely to be receptive to arguments that personal sacrifice in the public interest is just the right thing to do, or even to

go further and to accept that the distinction between private and public interest is artificial as they are one and the same. Instead a consumer is likely to ask *what is in it for me?*

Someone who owns property where a new hospital or road is to be built, which is subject to a compulsory purchase order to allow the project to go ahead, could reasonably ask for compensation at the market value of that land. Similarly, a person suffering from diarrhoea and vomiting who normally works in a restaurant, may be prepared to stay off work until they have been cleared as an infection risk, provided they continue to receive their wage paid by their employer or an agency acting under public health law. Even altruism could be viewed within such a compensation framework, albeit in a non financial sense. The utility that someone gives up by being prevented from exercising their autonomous choice is instead compensated by a greater sum of utility for knowing that someone else, usually to whom they have a connection if only through common community membership, is better off.

People may be willing, albeit grudgingly, to pay taxes as part of a contract to receive services from the state. They may perceive their taxes as contributions towards a fund for health, pensions and other social goods that they can draw on in the future, in the same way that they would if they were paying towards a personal pension, or health insurance plan. In reality they are only paying for current users of health care or elderly people. Their own social benefits are dependent on an expectation that the next generation will make the same *altruistic* sacrifice.

People who pay taxes towards public services or make charitable donations that they believe that they may never benefit from, or at least not to the extent of their contributions, may not be motivated by our altruism, but rather by a form of *self-interested altruism*. This of course may appear to be an oxymoron as the two concepts of altruism and self interests should not be compatible with one another.

For example, a person may be happy for their money to provide shelters for the homeless, therapy for people with drug addiction, or even the education of other people's children if they themselves are childless. These may be considered to be worthy causes in their own right. A roof of your head may be considered a basic human right. Drug addiction is associated with significant reductions in quality of life and threats to health. Education permits widening of the mind, exposure to the arts etc. However, a *self-interested altruist* may consciously or unconsciously see more direct personal benefits from *helping* others. They may be spared having to see people begging or sleeping on the street, which perhaps makes them feel guilty, or impairs the *aesthetics* of their environment. Drug addicts commit crime in order to purchase drugs. *Self-interested altruists* may be the victim of this crime. A better educated society is also likely to be associated with lower crime rates, as well as being economically more prosperous and hence a better place for the *self-interested altruists* to live. Thus while an individual may have a first order preference to pay low taxes, he or she may be willing to pay for others to benefit, providing it fulfils their second order preferences to live in a society that is compatible with their personal interests and goals. These interests and goals could be purely altruistic, but are usually connected in some way with their own personal interest. This is perfectly acceptable, and citizens should not be criticised in acting in this way. It merely reflects the difficulty in separating private from public interest.

8.2.1 Implications of *self-interested altruism* for Public health

In our modern consumerist society, appeals to individuals to acquiesce to public policy that may not appear to be compatible with their direct or immediate private, interest, may not be effective. Of course, individuals may feel good by acting out of what appears to be altruism, but when designing messages for the public, policy makers need to ensure that citizens implicitly understand what they will be getting out of the policy in terms of their second order preferences. For example, that it will save them having to pay tax in the long run, or they would be similarly supported if it were to happen to them in the future, or it means that they may live in a society compatible with their goals. Thus policy makers need to be much more sophisticated in their campaign messages and hence need to research public attitudes, concerns and motivations more carefully. While the principle of autonomy is not a good basis for deriving an ethical framework for public health practice, political realities mean that if policy is to bring about improvements to the public health in a consumerist society, it will be necessary to work in partnership with the *self-interested altruist*.

8.3 *It Could Be Me: On the Hazy Border between Self-interest and Solidarity*

Debates on health policies are often polarised to oppose self-interest with solidarity. This polarisation manifests itself in many different ways, that all have the common denominator of pointing towards the desirability (solidarity) or undesirability (self-interest) of collective solutions to health problems, which makes it particularly interesting from a public health perspective. In some cases, claims that people are basically self-interested/solidaric are used to this end; sometimes the very content of arguments are held out as being based on norms prescribing satisfaction of people's self-interest/solidarity with all people. In any case, the polarisation assumes that self-interested and solidaric opinions can be clearly distinguished on a methodological level. In this chapter, this basic assumption will be questioned on the basis of some particular results of the EuroPHEN focus groups. Especially, these results indicate that just asking people where they position themselves with regard to the self-interest – solidarity dichotomy is a poor predictor of their basic moral stance, and, in particular, that people holding out themselves as basically self-interested may well appear to be much less so when interpreted in a richer context of expressed patterns of reasoning.

8.3.1 *The It Could be Me Phenomenon*

Within the EuroPHEN focus groups, the respondents were asked to take a stand on two opposing ideas on how to organise health policy in terms of two imaginary countries, 1 and 2. Country 1, (C1) was described as providing publicly financed health services to all citizens while in country 2 (C2), health services were described as accessible almost only through private means. As a consequence, taxes were described to be significantly higher in C1, while the number of alternative health service forms and providers were significantly lower than in C2. Almost every respondent ended up expressing a clear preference for C1, and most of these motivated their stand in ways pointing towards a stance that can be broadly described as solidaric. However, one particular minority reasoned in a more complex way. They started out with an initial preference for C2, motivating this stand with the claim that they would fare well within this type of policy, while recognising that several others would not, and therefore benefit more by it (due to lower taxes and access to a larger range of alternative health service providers). However, having made this initial declaration, they then added that although they indeed believed themselves not to belong to the *losers* in C2, *it could be me* (ICBM), and on this basis they concluded that, all in all, C1 was after all the more desirable option.

Psychologically and sociologically, it may of course always be asked what happens in people's minds when they express their opinions, especially in a group. Are they really being true about their views, or are they adapting to the expectations of others, for example? Or do they lack any clear opinion, thus constructing one on the spot? However, since this type of doubts is applicable to any opinion, it does not seem to cast its shadow on the ICBM phenomenon in particular. Of more basic interest is the question how the *content* of ICBM could and should be interpreted. Should it be seen as describing a shift of moral stance, where an initial commitment to self-interest is exchanged for a more solidaric view, for instance? Or does it signify something else? In any case, the mapping of people's moral values obviously is a more complicated task than just asking them to declare their views. In the ICBM case, people's views are rather uncovered by letting them perform a complicated

line of reasoning. And, as will be briefly sketched, such lines of reasoning are as a rule open to many different interpretations.

8.3.2 The Content of ICBM: Three Interpretative Categories

ICBM might simply express a more careful analysis of what is of benefit for oneself. While indeed believing that one would fare better in C2, on second thoughts one realises that conditions may change or that one may have an exaggerated picture of one's abilities. Here, the initially expressed commitment to a self-interested outlook stands untouched – all that ICBM signifies is a more careful application of this outlook to the issue at hand. An advanced version is to interpret ICBM as the expression of a rational bargain, where the wider consequences of having or not having losers in society is taken into consideration, but still from a purely self-interested perspective.³⁶¹ This type of interpretation analyses ICBM as a type of rational reasoning pattern that does not require a shift away from self-interest as a basic moral stance.

However, other suggestions for such patterns that might fit ICBM rather indicate a (rationally required) shift of basic moral stance. Two of these could be described as Kantian:³⁶² either in the form of a generalisation of the original self-interested view (what if everyone reasoned like this, what would then become of me should I not fare as well as I believe, and is that acceptable?), or as a universalisation (what if I had been in the loser's shoes, would I then have preferred C2?). If the answer in either case is negative, rationality is assumed to require abandonment of the view that thereby cannot be generalised/universalised – in this case, self-interest. Very close to the universalisation idea is the Rawlsian contractualist pattern;³⁶³ ICBM then indicates the position that a valid view has to be the one reached when one is unaware of one's actual position in society, and that therefore pure self-interest is inapplicable – one's appraisal has to be performed at a collective level.^{xix} Similarly, one version of communitarianism would suggest interpretations of ICBM where pure self-interest is ruled out as incoherent, due to the alleged fact that the border between oneself, others and the community is much less clear-cut than what is assumed by the self-interested argument for C2 (my interests are partly made up of the interests of others and the common good).³⁶⁴

Other versions of communitarianism would instead disqualify the initial self-interested argument for C2 because everyone are required by their role as members of society not to reason purely self-interested in the *sphere* of health,³⁶⁵ or because individual interests are simply not what is of most importance – even if self-interested, we should rather care for the common good as socially defined.³⁶⁶ ICBM could be interpreted as expressions of both these types of positions. Close to this is the interpretation according to which ICBM expresses a recognition of what a truly moral piece of reasoning requires: it cannot be purely self-interested, since one would then fail to take "the moral point of view".³⁶⁷ This brings us closer to the last interpretation, according to which ICBM indicates an initial confusion about the issue: the respondent first thinks that she should express a personal preference, but then realises that what is asked of her is an overall evaluation of which society would be the better one (not which one she personally would prefer to live in). The difference between these two questions is that the latter may be asked and answered without considering oneself as a

^{xix} It is, admittedly, possible to read Rawls so that he is rather putting forward the idea of a self-interested rational bargain. However, our reading of Rawls contractualism is that it is more constructivist: the initially assumed self-interest is a methodological assumption made in order to make the justification of the basic values of society constructed through the contractarian reasoning stronger.

member of the societies one is asked to evaluate. In all these cases, what ICBM expresses is the fact that the respondent's basic moral outlook is in fact not self-interested at all.

The variety of possible interpretations that may fit ICBM is in itself of interest from a methodological point of view, since it calls into question the two most commonly used methods for investigating people's values: simply asking people to position themselves among a number of basic positions (the polling method so often used in the surveying of public opinion), or deriving basic ethical stances from hypothetical choices among competing courses of action (revealed preference, nowadays often applied in form of the willingness to pay method). The weakness in both cases is that, if given an opportunity to reason, people's values may indeed shift, or they perception of the issue at hand may shift. Most important, though, reasoned opinions may reveal that initially expressed views are open to a number of competing interpretations. From this perspective, the focus group study of basic social evaluations may be seen as having revealed a sort of *process deliberation* methodology that seems to be particularly suitable for the study of evaluative and normative opinions and stances. However, both of the other methods also have virtuous features, and these may be possible to import into the process deliberation approach, for example, so as to have people conduct complex patterns of reasoning about their prioritisation within a willingness to pay scheme interpreted in different ways.

Are there any reasons to prefer any of the basic lines of interpretation sketched above? Many economists would probably prefer the first line of interpretation, since it would fit standard theoretical models better. However, that is a poor reason, since it means begging the question at hand: are people basically self-interested or not? To avoid that, a wider methodological rule could be applied: in social and behavioural science, other things being equal, we should prefer interpretations that picture people's opinions and pieces of reasoning as making sense and being roughly plausible. Applying that rule, it seems that the first two interpretative categories share a weakness, they both claim that ICBM expresses an allegedly rational pattern of reasoning. However, it may turn out that the reasoning is not so rational after all – especially since within and between the categories are expressed competing views on what rationality requires. In addition, it is not evident that any of the suggested patterns of reasoning in these categories would indeed support endorsement of C1 rather than C2. This weakness is avoided by the third type of interpretation, according to which the totality of the ICBM pattern should be seen as expressing a denial of self-interest as the respondent's basic moral stance.

9 Implications for a Normative Ethics Framework for Public Health

Within both the EuroPHEN strands examining differences between approaches to public health policy and attitudes of citizens, it was stressed that such evidence was not collected in order to derive a normative framework for public health. Such a framework must be derived from the EuroPHEN strand dealing with philosophical analysis. However, these other strands will have relevance to how any such a normative framework is developed into guidance documents for use within European institutions and Member States, e.g. in producing *code of conduct* by Public Health professional bodies. The legal and policy implications of EuroPHEN in terms of the critique of ethical issues within public health practice, must therefore be considered in conjunction with the future research needs that EuroPHEN has also identified.

9.1 The Goals of Public Health

The societal practice of Public Health is driven by goals that are expressed explicitly by various policy documents and regulations and/or implicitly by the way in which Public Health is organised, structured and motivated by professionals. Such goals express ideas about what values should be pursued by Public Health from an ethical point of view, and these in turn influence what is seen as desirable and defensible Public Health practice. Even if we disregard obvious ambiguities built into the very notion of Public Health, there is a significant variation between European countries, as well as between different temporal eras of one and the same European country, with regard to what these goals are taken to be.³⁶⁸ From the point of view of a harmonisation of Public Health policy across Europe, this fact is a serious challenge, since it necessitates a choice of what the goals of European Public Health *should* be.

In this concluding chapter, this question is addressed as a purely ethical issue about the proper content of the political ideology that should shape an envisioned European approach to Public Health. Five main types of goals will be sketched, connected to underlying ethical positions and compared, with some tentative conclusions to the benefit of the last suggestion. It is argued that this suggestion supports the idea of a complex and dynamic goal structure for European Public Health, and that such a suggestion also seems practical as well as desirable from the point of view of the realities of European politics.

A note should be made of the fact that the goals may be conceived of on different levels from a theoretical point of view. They may be taken to express rather directly some basic ethical claim about what is in itself desirable. However, they may just as well be seen as claims about what is sometimes referred to as *contributory values*, i.e. features that together with various other features make up states that are desirable in themselves. Finally, the goals may be seen as purely instrumental – based on empirical hypotheses they express the belief that attaining the goals will in turn lead to the actualisation of states that are desirable in themselves. A complete analysis of the goals of Public Health would have to systematically work through these different possibilities. In the present case, however, I will leave it open on what theoretical level they should be placed, and merely make some scattered hints at how the goal I will argue in favour of may be justified. The point argued is simply that seemingly conflicting goals may be combined into a coherent, complex structure that should be able to

satisfy most of those requirements that have been proposed with regard to the nature and ethics of Public Health.

9.1.1 Five Goals

It is a common idea of Public Health that its goals are population- rather than individual-based. This is seen clearly in the traditional goal of Public Health to *promote the health of the population*,³⁶⁹ where the latter is some kind of aggregate of the health states of individual members of the population in question.³⁷⁰ This feature sets Public Health apart from health care or medicine, where the traditional goal is to promote the health of the individual patient.^{xx} This difference is also seen in traditional ethical restrictions, where the primary one within Public Health is cost-effectiveness in terms of population health, while medical ethics focus on respecting the patient (her needs, fragility, and autonomy).

In recent years, requests for Public Health to incorporate concerns of medical ethics have increased, and in some cases new goals have been suggested that add new values to the traditional goal. The first of these is *equality*, made manifest by an increasing focus on health inequalities in Public Health monitoring, and measures aiming at empowering allegedly weak groups. The rather imprecise idea seems to hold out an egalitarian ideal that concentrates on the improvement of the health of those worse off in this respect, and that focus on unequal *opportunities* to be healthy rather than actual health states. The second suggested addition is to hold out *autonomy* as a value to be promoted by Public Health. Also here, an increased interest in the promotion of people's opportunities to choose to be healthy (if they want to) bears witness; showing itself in measures aimed at securing access to health promoting choices, empowering people to make such choices, and informing them about what choices are health promoting. There is also strong trend to underline people's responsibility for taking care of their health, implicitly implying that choices made should be respected by society even if they are not to the benefit of the individual. Both these ideas differ from and potentially conflict with the traditional goal. Promoting health opportunities may be very difficult and therefore cost-inefficient, and even if successful, people may still make unhealthy choices. The autonomy goal also actualises the conflict between concerns for individual freedom and the common good, as well as the individualist and the population approach already mentioned.

One central discussion within the EuroPHEN project has been about the suggestion that considerations of autonomy should be emphasised in Public Health. Two main reasons have been suggested for doubting this idea. First, it has been observed that holding out autonomy as central without recognising its intimate practical connection to a basic level of population health will make it into a thin concept of formal market freedom that is of doubtful ethical importance in itself. That is, autonomy has to assume that the basic material conditions of society are such that the formal freedom of people to choose is a real and practical opportunity for people to significantly improve their lives, compared to how they would have fared in other material circumstances. If this is not taken into account, having autonomy as a goal of Public Health may have the effect of conserving or further deteriorating social and material conditions that block beneficial opportunities for most people. Second, just holding out autonomy as desirable in an unqualified sense seems to imply that it should be the

^{xx} While promoting the health of the population must plausibly imply that the health of *some individual* is promoted, this individual need not be a patient in the medical or health care sense, and vice versa.

business of Public Health to boost the opportunities of people to make unhealthy choices. The perception that this is obviously wrong connects to the former complaint, but also to the third and final one. This argument makes the case that the idea of autonomy as a value to be strived for and promoted goes against the very nature of Public Health, since autonomy is essentially an individualist conception, while Public Health pursues values on a population level.

These conflicts could be weakened if, first, the traditional goal is given appropriate space and, second, the autonomy goal is made population rather than individual oriented.^{xxi} Some of this is secured in a fourth suggestion for the goals of Public Health, which combines the concern for equality and autonomy against a background of a general societal interest in good population health. According to this idea, the goal of Public Health should be to secure the equal opportunities of members of the population to choose better health.³⁷¹ While implying some amount of respect for individual choices not to use such opportunities, the idea implies that Public Health should only concern itself with providing health opportunities, and that the freedom to make unhealthy choices may be restricted if it impedes the opportunities of others to make healthy choices. However, this goal still does not acknowledge the traditional goal, and the arguments about the connection between autonomy and a decent level of population health mentioned above may therefore still apply. Suppose, for instance, that a very dangerous pandemic seriously threatens Europe – in that case it may be very difficult to uphold the ideal of equal health opportunities for everyone, and also difficult to claim that individuals refusing to comply with measures taken by authorities to prevent catastrophic scenarios in terms of health and, in effect, secure basic social and economic stability are impeding anyone's equal opportunities to choose better health (especially since these measures may counteract such equality). But, surely, society should apply such measures, so there must be something wrong also with this way of constructing the goals of Public Health.

This consideration seems to support a further addition to the fourth goal; namely that it holds under the provision that the health of the population resides on or above a sufficient level (i.e. the level at which the importance of individual control becomes strong enough to trump the importance of attaining an even better level of population health). That is, should the health of the population slide below that level, the traditional goal again becomes the primary objective of Public Health. This may also be applied in a preventive manner of reasoning: if it can be predicted with reasonable certainty that if the traditional goal is not taken as paramount, the level of population health will deteriorate below that point where the combination of equality and autonomy concerns formulated in the fourth suggestion trump the concern for population health, the traditional goal should be applied. This fifth idea of the goals of Public Health may be motivated by rather different ethical outlooks,^{xxii} all of which support the ideas that (i) improving the situation of the worse off is more important than improving the situation of the better off as long as a basic level of wellbeing is upheld on the population level, and (ii) the more wellbeing people enjoy, the more important it is that they are able to control how much wellbeing they enjoy.

^{xxi} Population orientation here means merely that a goal to promote autonomy is formulated in terms of certain features of a population, not necessarily that populations as such are ascribed varying degrees of autonomy. The latter would imply a strong communitarian idea.

^{xxii} Rawlsian egalitarianism, different brands of prioritarian consequentialism, as well as suitably constructed brands of communitarianism (where the proper concern for the common good is adjusted according to the just mentioned idea).

This idea will not appear acceptable to everyone.^{xxiii} However, besides the fact that it appears to be supportable on the basis of a broad range of different basic ethical positions, it seems to harmonise well with common sense opinions on the relative importance of social utility, individual freedom and equality. In addition, it does seem to accommodate the requests for incorporating medical ethical ideas into Public Health, as well as the insistence that the goals of Public Health should be exclusively population oriented and make suitable room for a direct concern for population health.

9.1.2 Application to European Public Health

Applied to the prospect of convergence of European Public Health, the above suggests a complex goal structure that is flexible with respect to different subject areas and regions/countries. Common to all aspects of European Public Health, is the shared interest of European Union to provide its population with opportunities for better health. If people want to remain or become more unhealthy, they will have to create the opportunities for this privately. What is more, it supports the idea that focusing on the traditional goal at the expense of equality and autonomy is appropriate in a particular region/subject area when the health of the population of this region/with respect to this area is sufficiently poor. If measures are successful, these conditions will improve, however, and in that case shifting focus from health levels to (equal) health opportunities is required. Should this, in turn, effect too much of unhealthy choices so that the health of the population deteriorates too much, shifting back to the traditional goal becomes justified (as mentioned, if such processes can be predicted, taking preventive measures that apply the traditional goal of promoting population health alone may be justified). However, as remarked, since opportunities to be unhealthy must not impede the equal opportunities of others to choose better health, such a development is not very probable, except in very special circumstances, where there are great health threats that directly affects the whole of society and creates real risks of socio-economic unrest or collapse (such as a pandemic of a very dangerous communicable disease that cannot be effectively treated).

Besides appearing to have good prospects for being well supported at a theoretical level, a goal structure of this complex type would also serve to facilitate the creation of European Public Health. This since it makes room for different countries/regions to make very different priorities within their own Public Health work, at the same time as they will all be contributing to promoting the goals of European Public Health. Another side of this is that, from the perspective of the European Union taken as a whole, this goal provides reasons for allocating Public Health resources for boosting population health in regions/countries that are worse off with regard to population health and be cautious in spending these resources on the further advancement of health-related equality and autonomy in countries that already score very well in terms of population health. So, at the same time, this goal seems to provide support for the idea of autonomy of member states to conduct their own Public Health policies, *and* the idea of an overarching European solidarity within the area of Public Health. Both of these ideas appear to be important for the long-term socio-economic stability of the

^{xxiii} Supporters of strong communitarianism, rely on an organic rather than a population conception of society (i.e. society as such is ascribed desires, strivings, needs etc. that are independent of the situation of the members of society), and radical libertarians, who discard any legitimate societal concern for the common good beyond that needed for securing formal liberty, are two examples.

European Union, and also to make the prospect of harmonisation and integration in the area of Public Health particularly appealing.

9.1.3 Further Issues to Consider in relation to goals

As indicated above, the suggestion regarding the prospect of actually justifying the fifth goal of Public Health on the basis of different ethical outlooks will have to be integrated with an analysis of on what theoretical level this goal may be placed. Considerable work remains before this has actually been undertaken. Here are a few issues of importance: (i) What is the range of variation with regard to the structuring of this goal with regard to theoretical level?, (ii) How should key concepts employed in the formulation of the goal be analysed in more detail and in relation to practice – in particular, the notion of equal opportunities to choose good health? Such an investigation would have to involve closer analysis of the concepts of equality and autonomy, as well as how these are applied in different ethical outlooks and political ideals. (iii) How can various ethical theories and political ideals be related to various ways of understanding the fifth goal theoretically? (iv) What (if any) practical difference will it make if the goal is justified on the basis of one set of basic values and norms rather than another?

9.1.4 Power and Authority

None of the philosophical theoretical frameworks above solve the so-called demos problem (i.e. the problem of who should be included among those that are given the opportunity to influence policy through democratic means and on what basis that is to be decided), although they may provide tools for approaching it. The importance of this problem relates to the perspective of European harmonisation of Public Health and the requirements that should face new member states. There is a delicate balancing in the intersection of these two processes between the perspective that new members have to adapt their policies to *official* European Union ideology, and the perspective that, as new members, they have the opportunity to change European Union ideology. This balancing is especially sensitive in areas where the harmonisation process is in the beginning, and where conflicts of basic values reside. The Public Health area is an example of both

Rather than the inclusion of people into the democratic domain, this problem concerns the inclusion of views/issues in that public arena where democratic deliberation is taking place. There is an intense discussion of this problem within liberal democratic theory (Rawls, Audi, Nussbaum, including deliberative democratic thinkers) that addresses the problem of how to handle issues/views that seem to be at odds with the shared basis of values (however thin it is) on which liberal democracy is founded. With regard to Public Health, this problem is particularly pressing regarding the issue of how to handle differing views on who (or what institution) should be given the authority to decide/teach/proclaim matters of fact. This theme can be connected to general issues about secular European society, and certain pressing value conflicts with regard to Public Health may be related to that

9.2 The Ethical Challenge to Public Health

Public health programmes promoting *health lifestyles* may be driven by the impetus to do good in society, but frequently they do so by enacting moral prescriptions as to how to live lives individually and collectively. Public health policy makers and practitioners traditionally act upon their own interpretations of what is in the public interest, although these interpretations diverge throughout the European Community depending on the political and public health traditions in the various member states. Despite this variation between Member States, the underlying structure of the *new European public health* is *to do good*: benevolence is the impetus of public health programmes, for what else is public health than to protect and improve the *health of the public*?

On this view liberty, freedom and autonomy are considered as stumbling blocks and barriers for any public health program. So many autonomous agents in modern Western societies exert their agency by drinking, smoking, not exercising, and many other unhealthy activities. All these irrational agents show that autonomy and freedom are virtual capacities and provide the legitimization to curtail civil liberties. The appeal for banning, mandatory and restrictive policies in public health is growing. Public health is developing more and more towards a paradigm of a disease-modelled, risk-oriented and individualistic directed activity of preventing bad things, designing effective and efficient methods and techniques to achieve the ends and goals set – not to smoke, not to drink, not to stress, not to live a life without exercise – without discussion on the goals themselves. Why should these ends be discussed anyway? Science has shown that these irrational activities lead to disease and disability, hence they should be subject to criticism, sanction and attack.

A paradigmatic shift in public health is required. Instead of pursuing a disease-oriented, protective and restrictive approach towards freedom and liberty, public health needs to reorient itself towards a strategy of building up relationships and enabling opportunities, social capacities and environmental conditions. In this respect the public health community should not consider autonomy as a bulwark against their programs of doing good, but instead as a personal and social condition of vitality, creativity and sociality.

Many of the ends set by the public health seem to be fixed and indisputable: stop smoking, avoid eating fat, exercise more, eat healthy food. The only remaining issue for the public health community would seem to be how to design better policies and methods for implementing these ends, the ends themselves need not to be discussed.

Although public health professionals tend to see themselves as being at the service of the public, any attempt to *do good* is inherently operating power and control. Justifying policies and methods in terms of benevolence does not mitigate this.

Power has to be legitimized. *Doing good* should be framed as doing right and the notion of public should encompass the power position of those, including public health professionals, who claim to do good on behalf of society. Not only is *how ends are set* relevant, but also *how ends are imposed*. Whether the ends are set by the public health experts or the public, in executing these ends the public health community should not engage in a practice of making people do what one wants them to do through more or less persuasive or even compulsive measures.

The tenet of public health is to strive for the public good. Underneath lays the view of some way of aggregating the good (or the reduction of the bad). Utilitarian reasoning says something like to do good is to produce the most happiness and communitarian reasoning that which produces the most good to the community. Kant opposes this *grand* tradition in ethics and moral philosophy because it (a) presupposes that the consequences of one's action are central and (b) the consequences can be somehow calculated.

It is not sufficient to claim that doing good is by itself the legitimate ground for enacting public policies. If this were true, it would lead to claims that all kinds of behaviour considered by sections of society as *bad*, that is bad by itself and bad for others could be banned under the label of doing good to society. The judgment *bad* implies that people are annoyed and disgusted by it and that it provokes, if not physical, then certainly psychological and emotional harm. Conversely, this implies that all kinds of behaviour considered *virtuous* by the majority of the population can be the legitimate ground of public policies. This leads to the moralizing of politics.

One might argue that many public health programs and policies do not aim at promoting *good behaviour* only, but instead attempt at proposing health and related conditions in terms of equity and fairness, say by promoting equal opportunities and defining health as a resource for social participation. If so, then such programmes and policies cannot frame the issue in terms of benevolence. The benevolent policy should be a just policy, a policy that performs the *right* thing.

There is an increasing trend towards arguing that people should be responsible for their choices. The assumption is that people understand autonomy as a matter of choosing important aspects of their lives from a variety of options and opportunities.

Most of these affairs should be the affair of citizens and not of the state, that is, that the regulation of the interplay between subject and object responsibility should have the *judge of the public sphere* and not government or any other public institution such as the public health community proposing *top down* mandatory measures. The additional point Kant makes is that one should instead start *bottom up*, promoting the capacity and vitality of the civil society.

Individuals have to be considered as the best judges of their own preferences, values and life plans. If citizens see it worth pursuing their ends, it is not legitimate to intervene for any reason other than what the individual aspires and permits.

All our collective measures to reinforce people's sense of responsibility by making explicit public announcements on the various issues of responsibility – do not smoke, do not eat fat, do exercise, refrain from stress, and so on – are supposed to strengthen our identification with the appropriate sources of subject and object responsibility. However, while trying to reinforce our notions of responsibility, public health measures as representative of other collective, coercive measures, may in fact weaken it. If we learn that coercive measures apply to the operations of our free will, we may respond progressively contracting the latter's domain. The paradoxical effect here is that in many instances behaviour has to be moralized and blamed for: the person is an addict, the person has no control over his or her body and mind, the person has to be corrected. Increasingly we have to describe actions in a deterministic vocabulary designed to place our free will, our selves, and our communal life at the periphery of self and communal life that is outside the boundaries of social life. This in fact leads to minimalist forms of constitution of selves and communities. In some cases, we

really need to restrict behaviour and to enforce legal sanctions as in the case of being attacked by murderers or terrorists. However, in most cases, similar approaches may be unintended and unwelcome. If the mishaps associated with driving, smoking, eating fat, exercising too little, living too ambitious lives and other kinds of behaviours considered to be unresponsive to society's needs and goals, carry with them severe social and legal repercussions, we may decide to give up all sorts of social behaviour which are vital and creative to individuals and communities. By cutting down responsibilities, individuals and communities may draw the boundaries of their selves and their identities more narrowly than they otherwise would have done.

Instead of making explicit public announcements of mandatory measures the public health community would be better off taking an *interactive* approach with the public, viewing autonomy and freedom as allies to promote the capacity, creativity and vitality of citizens living their lives as members of social networks and society.

10 Policy Implications

The EuroPHEN partners do not wish to make specific recommendations with regards to a code of professional ethics for Public Health. The normative framework that should underpin public health and issues in its implementation are laid out within the entire report.

Of particular importance are the sections of the report relating to the values of public health, and the challenge posed to public health professionals to reconsider their relationship with the public and the goals underpinning policy.

There are differences in approach to policy between Member States, which reflect local circumstances in terms of epidemiology and history, as well as variation in moral weight given to public versus private interest. However, these differences do not represent insurmountable challenges to developing professional codes for Public Health to be used within Member States or European Union institutions, nor for developing policy and European Directives.

The empirical research demonstrates current thinking among citizens towards public health and public policy more generally. The research also provides an indication of more effective ways of developing and implementing policy that attracts greater public support.

In summary, the following points should be considered:

- 1 Public health should strive to create an environment and structures that facilitate individual health, wellbeing and flourishing, and facilitate the interdependency between individuals necessary to achieve individual flourishing.
- 2 Public health should achieve population health in a way that respects the rights of individuals and the interests and interdependencies of communities. For some communities individual-focus bioethics is likely to be unsuitable and policy makers must be sensitive to the different needs and moral values of different communities.
- 3 Public health policies must take heed of the pre-eminence of autonomy in European society. However, the ability of citizens to make autonomous choices, sometimes for what may appear to be irrational behaviours that put them at increased risk of morbidity or mortality, should not be seen as an impediment to making improvements in the health of the public. Indeed, central to the normative framework proposed by EuroPHEN is the need to strengthen the autonomy of the public to promote the capacity, creativity and vitality of citizens living their lives as members of social networks and society.
- 4 Citizens consider themselves as *consumers* of healthcare who see health services as their *right* as tax payers. However rights have reciprocal responsibilities, and the public must be reminded of these. The method of informing the public about their rights and responsibilities as a citizen is a process that is lifelong, starting with school education.
- 5 Public health has a strong role to play in ensuring that people feel part of a society so that they can make a contribution to society. Identifying disenfranchised members of society is difficult because by definition they tend to be invisible and inaudible. They may not want to be identified because they think society is not relevant to them.

- 6 The public are unlikely to support policies which they do not understand or which they see as unconnected to their lives.
- 7 Public health policy should be implemented in a transparent manner that facilitates accountability, including the provision of all information and evidence used to inform the decision making process. Policies which are seen as un-enforceable will not only decrease support but also weaken support for public health policies in general.
- 8 There is a need to actively build trust in public health policy and for public health structures to be seen as independent from lobby groups, political, commercial and monetary influence.
- 9 A balanced approach is required between incentives and restrictions. The public generally prefer incentives to change behaviour etc, rather than more explicit, direct restrictions on what may be considered to be civil liberties. However, public health polices must be cautious regarding the use of inducements as these can create distrust. Inducements directed towards the medical suppliers of public health services can be seen as creating commercial interests which may biased what is best for the individual. Inducements directed at the general public can raise *conspiracy* type worries, especially in those cases where public information is lacking or where there is conflicting information given from alternative sources.
- 10 Public health institutions should respect the confidentiality of information that can bring harm to an individual or community if made public. In cases where there is high likelihood of significant harm to the individual or others, suitable mechanisms should be in place to retain a level of confidentiality that minimises the breach in privacy.
- 11 Where there are risks to health, public health institutions should act in a timely manner on the information available, taking into account the reliability of the data and other priorities.

11 Future Research needs

11.1 Further qualitative research

It would be beneficial to conduct further qualitative research focusing on the meaning of community and solidarity. The research could explore to what extent they are important within a 21st concept of citizenship and community. EuroPHEN conducted focus groups in 16 countries, but in further research it may be more effective to reduce the countries, but increase the demographics groups studied, and to have similar group profiles in all countries researched. It would be beneficial to explore these concepts in specific groups e.g. ethnic/religious groups, gay community etc. EuroPHEN included Poland, but with the further expansion of the EU, additional perspectives should be included by conducting the research in other central and eastern European countries and Turkey.

It seems to be a valuable prospect to conduct such research on the basis of developed versions of the initial focus group methodology. Among other things, adapted elements from other methodologies (for example, willingness to pay approaches), may be brought into the focus group set-up to facilitate more close investigations of attitudes to conflicts of interest, community concepts, etc

11.2 Quantitative research

The findings of EuroPHEN should be used to develop questionnaire surveys. Health economics techniques could be used to assess strength of support/opposition to Public Health policy e.g. willingness to pay, or compensation required.

Of particular interest is to survey, first, attitudes to particular types of policies/policy areas, and, second, particular types of value sets that may conflict in the public health context – such as, equality, economic and social efficiency, community autonomy, and individual liberty. It is moreover of interest to correlate the results of such surveys to economic features (such as growth) of the nations of the respondents, religious confession etc.

In light of the results of EuroPHEN, one other factor which is of considerable interest to survey quantitatively is citizens' trust in various social institutions with regard to issues related to public health and health policy. Comparisons between different countries and connections to other issues, such as the development of ethical guidelines for the public health profession, and the value sets mentioned above.

11.3 Research with the Public Health Community

It was originally the intention of the EuroPHEN Partners to develop an ethics normative framework that could be used by public health professionals. The partners decided that further work would be needed to do this involving a consultation process, similar to that used by the Public Health Leadership Society in the USA. Although the EuroPHEN Partners do not feel that a list of principles would not be helpful, as it could address the complexity of public health practice in its various settings. This consultation should also include a discussion of goals and methods of Public Health and examine the impact of private sector, lobby groups.

There are three basic models for how this may be done:

- 1 a top-down approach, where public health agencies and organisations (e.g. the European Public Health Association [EUPHA] and the professional bodies in Member States) are brought together to create a shared outlook.
- 2 a bottom-up approach, where the ideas of individual Public Health-professionals are surveyed in various ways (using quantitative and/or qualitative methodologies).
- 3 a combination of these.

Of these, the third option looks like the most promising, but it is also methodologically challenging when it comes to bringing the *top* and the *bottom* together. In the first instance, an international conference could be organised to initiate this process.

11.4 Conceptual projects

Perhaps the most important issue arising from the EuroPHEN report is the need to further consider the goals of Public Health. This is an important conceptual task for Public Health Professionals, public, politicians and other stakeholders.

Further philosophical research is required to explore concepts such as solidarity, equality and attitudes to risk. Such research should attempt to describe what specific public health policies would look like if based on a particular normative framework, to examine the differences between liberal, Kantian, communitarian, utilitarian approaches. It would also be beneficial to consider how to communicate/promote *public* values in *private* societies.

With special consideration to European harmonisation in the area of public health, it is of interest to relate these investigations to broader considerations about the forms and ideologies of European secularised societies, since these approach issues about the various points of conflicts between general society, sub-community- and individual interests mentioned above. It also connects to the issue of the importance of trust, and the related and crucial issue of who or what should be given the power/authority to represent the basis of knowledge that needs to underpin any activity within the public health area.

Appendix 1: Codes of Conduct

United Kingdom

General Medical Council

The duties of a doctor registered with the General Medical Council

http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp

Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern
- treat every patient politely and considerately
- respect patients' dignity and privacy;
- listen to patients and respect their views
- give patients information in a way they can understand
- respect and protect confidential information
- make sure that your personal beliefs do not prejudice your patients' care
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise
- avoid abusing your position as a doctor;
- and work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must be prepared to justify your actions to them

United Kingdom

Nursing and Midwifery Council

The NMC code of professional conduct: standards for conduct, performance and ethics

<http://www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=201>

As a registered nurse, midwife or health visitor, you are personally accountable for your practice. In caring for patients and clients, you must:

- respect the patient or client as an individual
- obtain consent before you give any treatment or care
- protect confidential information
- co-operate with others in the team
- maintain your professional knowledge and competence
- be trustworthy
- act to identify and minimise risk to patients and clients

Germany

Code of Conduct for the Medical Profession in Germany

The "Code of Conduct" printed here is in its essence the (prototype) code of conduct resolved upon in the 100th German Medical Congress and amended in the 105th German Medical Congress, the 106th German Medical Congress, and the 107th German Medical Congress. The Code of Conduct becomes effective when constituted by the Medical Associations in their assemblies, and approved by the regulating authority.

Vow

The following professional vow applies to every physician:

- On entering the medical profession I solemnly vow to dedicate my life in service to humanity.
- I will exercise my profession scrupulously and with dignity.
- The preservation and restoration of my patients' health shall be my paramount obligation.
- I will observe all confidential information, even beyond the patient's death.
- I will preserve the honour and noble tradition of the medical profession to the best of my ability, and I will not make a difference between religion, nationality, race, political affiliation, or social position in the conduct of my obligations as a physician.
- I will respect all human life beginning with conception with reverence, and I will not use my medical skills in contradiction to the laws of humanity, not even when under threat.
- I will pay due respect to all my teachers and colleagues. All this I vow on my own honour.

A. Preamble

The code of conduct, resolved on the basis of laws by the associations and healing professions, reflects the medical profession's determination as to the conduct of physicians towards their patients, their colleagues, other partners in health care, as well as their appearance in the public. To facilitate this, the German physicians have given themselves the following professional code of conduct. At the same time, the code of conduct with its determination of professional obligations serves the objective of:

- maintaining and enhancing confidence between physicians and patients;
- assuring the quality of the medical performance in the interest of public health;
- preserving the freedom and reputation of the medical profession;
- encouraging conduct worthy of the profession and to anticipate any conduct not worthy of it.

B. Professional Rules of Conduct

I. Policy

§ 1 Tasks of the medical profession

- (1) Physicians serve the health of individuals and the public.
The medical profession is not a trade. By its nature, it is a free profession.
- (2) It is the physicians' task to preserve life, to protect and restore health, to alleviate suffering, support the dying, and to collaborate in maintaining the natural foundations of life in respect of their importance to human health.

§ 2 General professional duties for physicians

- (1) Physicians carry out their profession according to their conscience, the obligations of medical ethics, and humanity. They may not accept any policy or observe any rules and directives not consistent with their tasks, or the abidance of which they cannot take responsibility for.
- (2) Physicians must execute their profession diligently and live up to the trust they encounter in the course of their professional practice.
- (3) The principles of correct professional medical conduct in Chapter C are part of this diligent professional execution.
- (4) Physicians may not take any orders from non-physicians in the execution of their medical decisions.
- (5) Physicians are obliged to keep informed about the regulations guiding their profession.
- (6) Irrespective of their special duties of notification and information specified in the following regulations, physicians are required to respond to any enquiries in reasonable time that the medical association may address to them in compliance with its legal duty of supervision.

§ 3 Contradictory terms

- (1) Apart from practising their vocation, physicians are not allowed to engage in any other occupation which may contradict the ethical principles of the medical profession. Physicians are also prohibited from using their name in connexion with a medical occupational title in an unfair fashion for commercial purposes. Nor may they allow their name or the professional reputation of physicians to be used in such a manner.
- (2) Physicians are prohibited from distributing products and other items or have them distributed with their assistance in the course of their medical practice, and they are not allowed to render trade services or have them rendered with their assistance unless the distribution of the product or service is a necessary part of medical therapy due to their special properties.

Poland

Medical Code of Ethics passed at 3rd General Assembly of Physicians and Dentists on 12th-14th December 1993, Warsaw

http://www.nil.org.pl/xml/nil/wladze/nil_eng/med_code

- The physician's vocation is the protection of human life and health, the prevention of disease, the treatment of patients and the relief of suffering. The physician shall not use his/her medical knowledge and skills for any purpose being in contradiction with that vocation.
- The physician's ethical imperative is the good of the patient.
- The physician shall perform all diagnostic, therapeutic and preventive procedures with due exactitude and appropriate allocation of time.
- The physician should treat his/her patients with consideration and courtesy and show due respect for their personal dignity and privacy.
- The physician is bound to observe medical confidentiality. Information acquired by the physician in the course of his/her professional duties, concerning the patient and his/her background is confidential. The death of the patient does not release the physician from the duty of confidentiality.
- It comes within duties of each physician to constantly supplement and improve his/her professional knowledge and skills as well as to share own experience and skills with other fellow-physicians.

Finland**Finnish Medical Association**

http://www.laakariliitto.fi/e/ethics/code_of_ethics.html

A person working as a physician has undertaken a great and demanding task, which cannot be fulfilled unless there is, in addition to proper knowledge, a serious desire to meet the ethical responsibilities acknowledged by the medical profession for thousands of years. A physician gains trust on the basis of personality, knowledge and proficiency. In accordance with these principles, the Delegate Committee of the Finnish Medical Association has adopted the following code to be observed by physicians in their profession.

I It is a physician's duty to protect human life and alleviate suffering, with the promotion and establishment of health as the principal aim.

II A physician shall serve his fellowmen charitably and show himself by his behaviour and actions to be worthy of the trust and respect that his task requires. He shall never participate in torture, the implementation of a death sentence or any other inhuman actions or preparation thereof.

III A physician shall treat patients as equals and not allow race, religion, political views or social status to have any effect on his actions towards them.

IV A physician shall not use his authority to undermine a patient's right to make decisions concerning himself. Even where the patient cannot convey his own will, it is incumbent upon the physician to act in the patient's best interest.

If a physician is compelled to make decisions concerning examinations or therapy irrespective of the patient's will, such decisions shall always be made on medical grounds.

V A physician shall maintain and further his knowledge and skills, and shall recommend only those examinations and therapy that are considered effective and purposeful on the basis of medical knowledge and experience.

VI Should a physician wish for his patient to participate in a clinical trial in which the examinations and therapy deviate from the normal procedure for the disease, he shall obtain the patient's freely-given consent without pressure, the patient being aware of the trial and of the additional strain and risks involved. Generally accepted declarations and instructions issued by the authorities shall be observed during the trial.

VII A physician shall maintain medical confidentiality and encourage his subordinates to do so.

VIII A physician may not seek unfounded tangible interest. He shall treat patients according to their need and collect a fee on the basis of the work carried out.

IX When issuing certificates and statements a physician shall bear in mind that he is an impartial witness or expert whose statement must be based on the objective findings of a thorough examination, on their critical evaluation and on other facts observed.

X A physician must observe strict consideration and avoid self emphasis when appearing in public. When advertising, a physician shall observe instructions on the advertising of physicians and medical services.

XI A physician shall nor become involved in medical care in which he does not have the freedom to act according to his duties and the principles of this code.

Norway**The Norwegian Medical Association****Ethical rules for doctors****(passed by the landsstyret in 1961 and amended in 2002****<http://www.legeforeningen.no/index.gan?id=485>)****1 Common conventions**

§ 1 A doctor shall cherish human health. The doctor shall heal, ease and comfort. The doctor shall help the ill to regain their health and the healthy to preserve theirs.

The doctor shall base their actions on the respect for human rights and on truth and justice in relation to the patient and society.

§ 2 The doctor shall look after the patient interests and integrity. The patient should be treated with warmth, caring and respect. Working with the patient should be based on mutual trust and shall, where it is possible, build on informed consent.

§ 3 The patient has the right to information about their own health and treatment and the right to look at their own records. The patient shall be given as much information as they wish. Information which is thought to be particularly distressing should be communicated carefully.

§ 4 A doctor shall preserve confidentiality and show discretion regarding information she/he is given as a doctor. The ethic for confidentiality and discretion can be more expansive than that which is provided for in law. Releasing information must be based on the patients own agreement or that provided by law.

§ 5 At the final stages of life the doctor must show respect for the patient own decisions. Active help to die, advice about how to die, and actions which could hasten the patient's death should not be given. A doctor must not help a patient to commit suicide. To stop treatment or to not start a treatment is not seen as active death-help.

§ 6 When a patient requires quick and emergency medical help, this shall be provided as swiftly as possible. The duty to provide emergency help disappears if they are sure another doctor is available to help. A doctor can refuse to take a patient under treatment, if they have the possibility of receiving treatment from another doctor.

§ 7 A doctor must not exploit a patient, either sexually, economically, or religiously or in any other way. The patient's consent does not absolve the doctor of responsibility. A doctor must not begin a sexual relationship with a patient.

§ 8 A doctor should be aware of their patients' economic situation and not seek unreasonable amounts.

§ 9 A doctor shall, in examination and treatment, only use those methods which are recognised as acceptable. Methods which put the patient in danger must not be used. If the doctor can not provide a certain method they should make sure the patient gains this treatment through another doctor. The doctor must not use or advice methods which they are unqualified to perform. A doctor must not allow themselves to be pressurised into using methods which they find incorrect. The care of the research person should be paramount when trying out new methods.

§ 10 A doctor shall maintain and improve their knowledge. Depending on their own competency a doctor should seek to educate and improve their medical knowledge.

§ 11 Depending on qualifications a doctor should provide the authorities objective information concerning medical questions. A doctor who speaks to the media about medical questions should secure the right to control how their comments are published.

§ 12 A doctor shall in their actions take care regarding society's economy. Methods which are unnecessary or excessively expensive should not be used. A doctor must not enter into alliance with the pharmaceutical industry and/or accept the supply of medical equipment which can lead to their professional independence being compromised. The doctor is obliged

to insure that medical resources are shared according to general norms and ethics. A doctor must not in any way seek to punish single patients or groups with economic burdens or in other ways prioritise patients. If there is a lack of resources in the doctor's own work area they should make these known.

1 Rules for doctors in relation to co-workers and colleagues

§ 1 A doctor should show colleagues and fellow workers respect, help, advice and counsel.

§ 2 If a doctor detects signs of professional or ethic failing of their colleague or fellow worker, they should first take this up directly with the person. Care should be especially with students and training doctors. If this does not solve the matter, the doctor should take the matter up with the administrators superior or concern the health authority. If the doctor detects signs of illness or misuse of drugs in a co-worker or colleague then they should offer help.

§ 3 A doctor should take care of their own health and should seek help if it is needed.

§ 4 A doctor must be careful when criticising colleagues in front of patients and others and must always have the patient's best interests at heart.

§ 5 During official debates between colleagues questions regarding medicine and health politics should be debated dispassionately.

§ 6 The referral of patients between colleagues must build on medical and health policy questions and patients need for continued health cover.

§ 7 Doctors must communicate open and confidently with each other. Information between doctors about patients shall be quick and contain all necessary details.

§ 8 Referrals must not be steered by personal economic interests.

Ethical Rules of the Swedish Medical Association (2002)

<http://www.lakarforbundet.se/templates/ArticleSLF.aspx?id=2830>

The person who has chosen the profession of a physician has accepted a difficult and responsible task that requires good knowledge and a willingness to comply with those ethical standards that physicians through millennia have recognised as valid. The trust and freedom befalling a physician is based on his personal qualities, knowledge and skills.

The person who is admitted into the Swedish Medical Association shall always let the following rules guide his action, and shall not participate in such activities where the freedom to act on such guidance is limited.

1. A physician shall have the health of the patient as a primary aim, and if possible cure, often aid, always comfort, thereby following what is commanded by the love of humanity and honour.
2. A physician shall act in accordance with science and tried experience, continuously strive to widen his own base of knowledge, and as far as he is able contribute to both scientific progress and the awareness of this progress among the general public. As far as possible, a physician shall always be ready to assist others with his knowledge.
3. A physician shall seriously consider the importance of protecting and preserving human life, and as far as he is able assist people in situations of medical need. A physician is never permitted to contribute to the active advancement of death.
4. A physician shall treat the patient with empathy, care and respect, and is not allowed to use his professional authority for restricting the patient's right to decide with regard to himself.
5. A physician shall respect the patient's right to information about his health status and available procedures for treatment, and as far as possible in this treatment proceed on the basis of informed consent, as well as abstain from communicating information about matters of which the patient does not wish to be informed.
6. A physician shall never relinquish the principle about the equal worth of every human being, and never subject a patient to discriminatory treatment.
7. A physician is not permitted to engage in a sexual relation with a patient in his care.
8. A physician shall when motivated consult other specialists, and welcome and assist a patient who wishes contact another physician.
9. A physician shall be secretive about all information about individual patients, unless this would jeopardise the patient's health or other interests.
10. A physician shall not give council, advice or recommendation, unless he has investigated the patient or otherwise acquired sufficient knowledge.
11. A physician is not allowed to be affected by illegitimate economic considerations, and shall never perform any other investigation or treatment than what is medically motivated. The fee shall be proportionate to the type and magnitude of the procedure performed.
12. Without failing to respect the interests of patients, a physician shall respect the work of colleagues.
13. A physician is never permitted to contribute in any way to the execution of death penalty, torture, or other cruel and inhuman practices.
14. A physician shall in his practice contribute to the use of medical resources in accordance with these rules, and never participate in illegitimate affirmative action with regard to individual patients or patient groups, whether in economic, medical or other respects.
15. A physician shall in certifications and assessments only confirm that which he after close consideration finds to be founded on facts and professional opinion, and distinguish this from other information, the truth of which cannot be assessed.
16. A physician shall not engage in obtrusive marketing of his services, and abstain from any other activity that improperly draws attention to his person or professional activities

United States of America**American Medical Association's Nine Principles of Medical Ethics**

American Medical Association. Principles of Ethics. Adopted by the AMA's House of Delegates June 17, 2001. <http://www.ama-assn.org/ama/pub/category/2512.html>

1. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
2. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
5. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
7. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
8. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
9. A physician shall support access to medical care for all people.

United States of America**United States Public Health Leadership Society Principles of the Ethical Practice of Public Health**

<http://209.9.235.208/CMSuploads/PHLSposter-40152.pdf>

<http://209.9.235.208/CMSuploads/PHLSethicsbrochure-40103.pdf>

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

Appendix 2: Topic Guide used for Focus Groups

RECRUITMENT QUESTIONNAIRE

Good morning/afternoon. I am an interviewer from (AGENCY) and we are conducting some public opinion research. Could you please spare a couple of minutes to answer a few questions?

GENDER

| | | |
|--------|---|-----------------|
| Male | 1 | RECRUIT |
| Female | 2 | TO QUOTA |

EDUCATION (local definition)

| | | |
|-----------------------------|---|-----------------|
| Further education achieved | 1 | RECRUIT |
| Standard education achieved | 2 | TO QUOTA |

WORKING STATUS

| | | |
|-------------------|---|----------------|
| Working full time | 1 | |
| Working part time | 2 | RECRUIT |
| Full time student | 3 | A |
| Housewife | 4 | MIX |
| Retired | 5 | |
| Unemployed | 6 | CLOSE |

No more than 3 students or housewives in any one group, must have at least half of each group in some kind of work

AGE

| | | |
|----------|---|-------------------------|
| Under 20 | 1 | CLOSE |
| 20-30 | 2 | RECRUIT TO QUOTA |
| 31-44 | 3 | CLOSE |
| 45-60 | 4 | RECRUIT TO QUOTA |
| 61+ | 5 | CLOSE |

LIFESTAGE

| | | |
|--|---|-------------------------|
| Single/ co-habiting, Without children | 1 | RECRUIT TO QUOTA |
| Married/ co-habiting/ live alone, with children (or have children who have left home) | 2 | RECRUIT TO QUOTA |

NATIONALITY

Are you a 'national' and been resident for 2 years?

| | | |
|-----|---|-----------------|
| Yes | 1 | CONTINUE |
| No | 2 | CLOSE |

QA) First, can you tell me whether you or any of your close family or friends work (or have worked in the recent past) in any of these professions?

| | | |
|---|---|-----------------|
| Advertising/ PR | 1 | CLOSE |
| Marketing/ Market research | 2 | CLOSE |
| Journalism. 3 | | CLOSE |
| Health industry (inc. pharmaceutical company) | 4 | CLOSE |
| Government* | 5 | CLOSE |
| Other | 6 | CONTINUE |

***CONTINUE** for civil servants e.g. teachers, and any not involved in policy decision making, local council etc.

QB) Have you ever attended a group discussion/ focus group or interview for the purposes of market research?

| | | |
|-----|---|-----------------|
| Yes | 1 | GO TO QC |
| No | 2 | GO TO Q1 |

QC) Have you been to a group discussion or market research interview in the last 6 months?

| | | |
|-----|---|-----------------|
| Yes | 1 | CLOSE |
| No | 2 | GO TO QD |

QD) How many group discussions or interviews have you attended in the last 2 years (i.e. 6 months – 2 years)?

| | | |
|-------------|---|-----------------|
| None | 1 | GO TO Q1 |
| 1 or 2 | 2 | GO TO QE |
| 3 | 3 | GO TO QE |
| More than 3 | 4 | CLOSE |

QE) For each occasion, could you tell me what was the subject of the market research group discussion or interview you attended:

.....

(WRITE IN SUBJECT MATTER FOR EACH OCCASION)

IF SUBJECT MATTER WAS RELATED TO HEALTH ISSUES, POLITICS OR GOVERNMENT POLICY, CLOSE

Q1 Which of the following best describes your attitude towards current affairs and contemporary social issues?

I am very active in working for 'political' issues and causes I believe in, I hold strong views on certain issues

CLOSE

I am interested in current political and social issues, and try to get involved when I can

CONTINUE

I have some interest in current political and social issues, and like to keep myself informed and up to date through discussion with friends, reading newspapers and magazines and watching news programmes on TV

CONTINUE

I am aware of current political and social issues from discussion with friends, reading newspapers and magazines and watching news programmes on TV

CONTINUE

I have no interest in current political and social issues and tend not to follow them in the news

CLOSE

Q2 Do you smoke?No..... 1 **GO TO Q3**Yes..... 2 **GO TO Q5****Q3** Have you ever smoked?No, never 1 **RECRUIT AS NON-SMOKER**Yes 2 **GO TO Q4****Q4** When did you give up smoking?Less than a year ago 1 **CLOSE**More than a year ago 2 **RECRUIT AS NON-SMOKER****Q5** Which of the following best describes you?I am an occasional/ social smoker (less than 10 cigarettes per day) 1 **CLOSE**I smoke between 10 and 25 cigarettes every day 2 **RECRUIT AS SMOKER**I smoke more than 25 cigarettes every day 3 **CLOSE****Q6** Which of the following best describes your attitude towards talking about issues that affect you and your family, and the country as a whole?I am quite private about certain things and think that political issues should not be discussed between friends and acquaintances **CLOSE**I am happy to discuss my feelings on certain issues and enjoy hearing what others have to say **CONTINUE**I always hesitate to discuss issues in politics or current affairs as I feel I may not appear very informed **CLOSE**I am happy to talk about my feelings on certain issues, even if I don't have all the facts **CONTINUE**

FOCUS GROUP DISCUSSION GUIDE

ATTITUDES TOWARDS PUBLIC HEALTH ISSUES

Explain that we are asking people's views on the balance between public and private interest. We are looking at the interests of the individual vs another individual vs society and want to find out when it is better to put emphasis on private interest versus the public interest.

Explain the need for open debate, honest revelation and respect for individual viewpoints – even if they are not politically correct.

1. COMMUNITY AND SOCIETY (15 mins)

I would like to start by talking about 'community' – what kind of community you live in and what you understand by the term 'community'?

Prompt: What sort of local community do you live in?

Prompt: How well do you know the people who live in your area or who you work with (e.g. do you know their names, can you ask favours of them)?

Prompt: Would you prefer to keep to yourself or to be close friends with those around you? Do you think that other people in your community feel the same way?

Prompt: If your neighbours asked questions about you, would you think they were being nosey or caring (e.g. if they see people they don't recognise hanging around outside your home, or if something was left on your doorstep)?

Prompt: How does this compare to when you were younger?

Prompt: What concerns you about the neighbourhood you live in?

Describe (in terms of words or images) the sort of society that you would like to live in?

Listen for/: Freedom to get on with life and look after yourself
prompt Caring society where everyone is looked after

2. COUNTRY SCENARIOS (15 mins)

Imagine two countries in which you could live. Imagine you have an average wage so the net amount you would pay for a standard package of healthcare/education/pension provision would be similar.

Country 1: The government provides a high level of public services - education, health, pension and social care - but taxes are high to pay for them, and because the government makes decisions, there are some limitations on choice about education, health and social care. If someone had a high wage they would pay more and poorer people would pay less, but all would have the same provision.

Country 2: Taxes are low, but people are expected to pay for insurance in case they become unemployed or ill and to make provision for a pension and social care when they are older. However because taxes are low they can make own choices about what sort of insurance/pensions to buy etc. All would pay the same for a particular package but people could choose to pay more or less to tailor their package to their needs.

Perceptions: What are the advantages/disadvantages of Country 1? And what are the advantages/disadvantages of Country 2?

Which country do you feel is most efficient in producing services?

On a scale between these two countries, where would you put our country?

What about people in the Country 2 scenario who do not make provision for themselves

Prompt: For instance some might choose to spend money on holidays rather than invest in the future, or are on low wages so find it hard to pay for insurance cover? What should happen to them if they need public services later on? Is it acceptable that these people should live in poverty/hardship/with no health services? How do you feel about this situation/these people?

Is it fair/right/acceptable that people with no children have to pay for the public education of others or people who are never ill should pay for the health care of others?

Prompt: What you get out of paying for someone else's education or health care? Would you go for a high tax country because it is important that everyone has a good standard of education or health or because you believe that there will be benefits for yourself? What might the benefits be?

Prompt: Does it make a difference whether they are unhealthy because they are unlucky or because they smoke, don't take exercise, unhealthy diet etc?

3. TWO LISTS; RIGHTS AND RESPONSIBILITIES (SPLIT GROUP, PAPER AND PENCIL) (10 MINS)

Rights as a citizen? Responsibilities as a citizen?

Looking at the list - do you think that you have enough/about right/too many rights versus responsibilities?

How do you feel about the responsibilities you have identified

4. PERSONAL FREEDOM VS SOCIETY'S RULES? (15 mins)

Are there rules in other aspects of our lives that you think are intrusive?

Prompt: Sign in the park saying do not walk on the grass (WHY???)

Prompt: Road traffic e.g. speed, parking where not allowed, wearing car seat belt, motorcycle helmets, alcohol limits whilst driving

Why do you think we have these rules?

Prompt: Are some necessary even if they restrict personal freedom?

Prompt: What makes you respect a rule as opposed to ignoring or flouting it?

Prompt: Is there a difference between rules that can affect others by your behaviour and those where only you would be harmed? e.g. interfering with fire devices e.g. car seat belt, motorcycle helmet?

Why do you think these issues actually become laws, i.e. why do you think the government needs to make laws on these issues when the evidence should be enough to make us do things voluntarily – e.g. car seat belt, motorcycle helmets

5. EVALUATING SPECIFIC ISSUES – 'NOT IN MY BACK YARD' (15 mins)

Imagine there are plans to build:

- a mobile phone mast
- a home for people with mental illness?
- a chemical plant making everyday items, like plastic or pharmaceuticals

in your neighbourhood. How would you feel about this?

Prompt: Effect on value of house, impact on health?

Prompt: They are worthwhile, but just wouldn't want them near your house?

Some people may say 'not in my backyard' – is this fair?

Should their protests be ignored or accepted? In what circumstances?

Should people accept some risks so that others benefit (e.g. mentally ill people cared for, jobs created in factories, mobile phone networks operate all over the country)

Prompt: The risks would be quite low?

Prompt: Or where risks are still not proven should we not proceed at all, e.g. no-one allowed to use mobile phones because controversy surrounds the safety of masts and handsets ?

Briefly, who would you trust to reassure you that benefits are likely to outweigh the risks?

Prompt: a civil servant, a public agency, someone with responsibility for public health, a politician?
Independent or government?

Do you think that government and/or public agencies provide the right amount of information about risks to our health?

Prompt: Should they give us all the information, which may confuse, or judge the type and amount of information we can handle?

Prompt: do they have the right to judge whether it is necessary to tell the public everything in all circumstances, or does controlling information suggest something else, e.g. protecting groups or commercial interests etc?

Prompt: examples may help – e.g. pill scares, mad cow disease?

6. SMOKING POLICY (15 mins)

Should we encourage people to stop smoking? (If so why? How?)

Prompt: Ban smoking completely (Why not, given well documented and accepted evidence of harm to health and number of deaths, etc)

Taxation on tobacco, banning advertising

Subsidised gum/patches, smoking cessation advice/support

Do you think that people ought to be allowed to smoke in public areas?

Prompt: Advantages/ disadvantages?

Prompt: Workplace, Bars/ restaurants, Public transport

Do you/ smokers always obey these restrictions on smoking? (Identify smokers, ex-smokers in the group)

Prompt: In what kinds of places do smokers tend to ignore these instructions?

Prompt: Why do you think smokers ignore these rules?

Prompt: Because not enforced

Prompt: Inadequate penalties

7. PARENTAL RIGHTS EXAMPLES

Should government have the right to make laws that affect how all parents bring up their children in order to protect a small minority of children? In what circumstances?

8. SMACKING OF CHILDREN

Research suggests that smacking a child could lead a child to believe that violence is acceptable. While a smack is not always harmful and can be a useful tool in teaching a child what is dangerous, a small minority of parents take this too extremes. To protect this minority of children do you think that everyone including parents are stopped from smacking children by law.

Does prohibiting smacking restrict the civil liberties of parents to bring up the child as they may feel best or protect the human rights of the child?

Is it a sensible law, as it might not be respected by some parents who physically/mentally/sexually abuse their children anyway?

8a. CHILDHOOD IMMUNISATION

There are scares from time to time about the safety of vaccines and while risks are low individual parents can become scared of the damage that the vaccine could cause to their own child.

Should the decision as to whether to vaccinate their own child be left to the parents? Or should vaccinations be enforced by the government to keep the disease (such as measles) out of society as a

whole – a disease which can cause more deaths and damage to more children than the risks associated with the vaccine?

9. JEHOVAH'S WITNESS

Should parents impose particular religious beliefs on their child? What about some beliefs such as being a Jehovah's witness where parents could refuse consent for their child to have a life saving blood transfusion.

10. VEGANS

Should parents be allowed to bring up a child as a vegan so potentially restricting the child's dietary input of essential nutrients? (Research suggests that vegan diets are not sufficient for a growing child.)

11. DRUGS EXAMPLES

Should government have the right to make laws that allow individuals to get involved in potentially harmful activities in an attempt to minimise harm to individuals and society overall?

Some people claim that softer drugs such as ecstasy and cannabis are no more dangerous than tobacco and alcohol, thus the individual should be allowed to weigh up the risks for themselves and exercise their own civil liberties. Many governments are considering legalising cannabis.

The government is not actually condoning the use of this drug (in an ideal world people would not use alcohol or tobacco either) but they are accepting some evils in order to try and prevent greater harm to individuals and to society.

11a. LEGALISING CANNABIS

Should cannabis be legalised -- use among young people is so common anyway, and they may be less likely to move on to harder drugs if they are not making contact with drug dealers?

What would be the advantages and disadvantages for society of legalising its use?

Should there be limitations – e.g. medical use only, controlled use only - in specific areas only, at home only, bought from specific (even government run) shops or outlets etc

12. NEEDLE EXCHANGE

What about providing clean needles for harder drugs such as heroin. Drug users who inject their drugs sometimes use dirty needles, share needles with other people and pass on HIV or other infections such as hepatitis. One way of reducing the transfer of these infections is to provide needle exchange schemes so drug users can at least use clean needles. Some people are concerned that these schemes can appear to condone drug use.

Should these people who are breaking the law be helped to stay healthier and reduce the spread of disease? What are the advantages and disadvantages for society of exchanging needles?

13. SUPPLEMENTATION OF FOOD EXAMPLES

Does government have the right to alter basic foods/water of the whole population to benefit a minority of the population?

In these examples, the supplementation targets vulnerable groups, especially children. People could have vitamins they need by having fresh fruit and vegetables in their diet or using fluoride toothpaste. However many people, especially the poor, do not. Thus it is easier for public health to add these things to food or water, as this ensures that everyone, especially vulnerable children, get them. But some claim that this restricts civil liberties.

14. ADDING VITAMINS TO FOOD

Some people do not have a balanced diet and do not eat as many vitamins as they need. One way to get round this is to add extra vitamins and supplements to cereals, bread etc.

Provided that these foods are properly labelled, people can choose to buy or avoid these as they wish. Do you tend to buy or avoid foods with such supplements, or don't you make a conscious decision one way or the other? (very complex – they may get sidetracked into discussing the benefits of artificial vitamin supplements vs. natural healthy food?)

14a. ADDING FLUORIDE TO WATER

It is also possible to add fluoride to the water supply. Fluoride is important for strong and healthy teeth. Fluoride is not harmful unless it is taken in extremely large amounts (not likely). Adding fluoride in this way is especially good for children who don't brush their teeth as often as they should.

Unlike adding vitamins to cereals, it is more difficult to avoid drinking water that has fluoride added. Do you think that some people would object to having to drink water with fluoride added? (Why should they unless there are bad side effects? Are there any?)

15. FOOD POISONING EXAMPLE

Should government have the right to pass on personal details or restrict an individual's activities and rights in order to limit a wider risk to health?

Imagine you have been to a restaurant or bought some food from a take-out restaurant and the following day you develop severe vomiting and diarrhoea. You visit a doctor who feels that you have very bad food poisoning which could be a danger to others and needs investigating.

Should the doctor pass on details of the case so that someone can investigate whether the illness is part of an outbreak, and perhaps withdraw the responsible food from sale or ensure that the person selling the food improves hygiene standards?

Prompt: What if the patient wants to maintain their confidentiality? Is looking into the source of the food poisoning to prevent other people developing food poisoning more important?

Imagine your job is preparing food – it could be in a restaurant or a hospital or a school.

Should the doctor or public health have the right to stop you going to work in order to protect the health of others/the children in the school/the people in the hospital?

Prompt: What if this meant you lost earnings/money? Would it be different if your wages were paid by the government while you had food poisoning (which is what happens in some countries like the UK)?

Prompt: What if laws like this made it more expensive to eat in a restaurant or to provide meals for hospitals or schools?

What about other diseases e.g. HIV or other sexually transmitted diseases? There is more stigma associated with these diseases and so a patient may be more concerned about confidentiality.

What about duties not to pass on infection to other people? e.g. sexual partners people you work with (e.g. if you have a cold/influenza)

Appendix 3: Data from European Social Survey

| | If you want to make money, you can't always act honestly | | | | | Total |
|----------------|--|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Austria | 7.0% | 23.9% | 21.5% | 29.9% | 17.6% | 2147 |
| Belgium | 12.6% | 31.1% | 15.4% | 30.5% | 10.4% | 1761 |
| Switzerland | 9.1% | 36.0% | 12.4% | 31.6% | 11.0% | 2107 |
| Czech Republic | 7.7% | 24.0% | 23.3% | 25.2% | 19.9% | 2878 |
| Germany | 5.9% | 30.3% | 20.6% | 32.3% | 10.8% | 2814 |
| Denmark | 3.1% | 18.2% | 15.4% | 43.3% | 20.1% | 1456 |
| Estonia | 5.2% | 32.3% | 23.2% | 31.3% | 8.0% | 1855 |
| Spain | 3.5% | 26.1% | 15.4% | 38.3% | 16.7% | 1633 |
| Finland | 9.4% | 24.3% | 18.8% | 29.5% | 17.9% | 1990 |
| France | 9.9% | 26.1% | 13.8% | 22.2% | 28.1% | 1799 |
| United Kingdom | 2.8% | 27.3% | 21.2% | 39.7% | 9.0% | 1884 |
| Greece | 15.4% | 36.2% | 22.1% | 20.9% | 5.5% | 2336 |
| Hungary | 10.6% | 30.8% | 24.1% | 27.4% | 7.1% | 1466 |
| Ireland | 5.9% | 33.6% | 12.4% | 40.9% | 7.1% | 2253 |
| Iceland | 4.3% | 27.3% | 12.8% | 36.5% | 19.1% | 554 |
| Luxembourg | 11.7% | 33.3% | 16.0% | 28.2% | 10.9% | 1584 |
| Netherlands | 2.4% | 18.5% | 14.3% | 49.8% | 15.1% | 1869 |
| Norway | 2.9% | 17.7% | 13.7% | 45.5% | 20.2% | 1749 |
| Poland | 7.2% | 39.6% | 17.9% | 28.0% | 7.4% | 1663 |
| Portugal | 4.2% | 15.5% | 13.7% | 41.2% | 25.4% | 1997 |
| Sweden | 3.0% | 23.8% | 16.8% | 39.4% | 17.1% | 1911 |
| Slovenia | 7.1% | 33.1% | 21.0% | 31.2% | 7.6% | 1415 |
| Slovakia | 5.0% | 26.3% | 26.9% | 35.9% | 5.9% | 1452 |
| Turkey | 23.7% | 25.5% | 9.1% | 29.3% | 12.4% | 1804 |
| Ukraine | 21.0% | 30.2% | 23.0% | 18.8% | 7.0% | 1888 |
| Total | 8.2% | 27.7% | 18.0% | 32.7% | 13.4% | 46265 |

| | If you want to make money, you can't always act honestly | | | | | Total |
|--------|--|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Male | 9.5% | 31.4% | 17.9% | 29.8% | 11.4% | 21383 |
| Female | 7.0% | 24.5% | 18.1% | 35.1% | 15.2% | 24813 |
| Total | 8.2% | 27.7% | 18.0% | 32.7% | 13.5% | 46196 |

| | If you want to make money, you can't always act honestly | | | | | Total |
|--------------|--|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| 24 and under | 8.7% | 32.3% | 22.0% | 28.0% | 8.9% | 6460 |
| 25-34 | 8.8% | 29.9% | 19.6% | 30.8% | 10.9% | 7426 |
| 35-44 | 8.5% | 28.4% | 17.4% | 32.7% | 13.1% | 8443 |
| 45-54 | 8.7% | 28.2% | 17.1% | 32.2% | 13.7% | 7844 |
| 55-64 | 7.7% | 26.1% | 15.5% | 35.3% | 15.3% | 6998 |
| 65-74 | 6.9% | 24.0% | 16.9% | 36.0% | 16.2% | 5485 |
| 75 and over | 6.4% | 20.8% | 16.9% | 36.1% | 19.7% | 3364 |
| Total | 8.1% | 27.7% | 18.0% | 32.7% | 13.5% | 46020 |

| | Occasionally alright to ignore law and do what you want | | | | | Total |
|----------------|---|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Austria | 3.7% | 25.0% | 26.0% | 29.7% | 15.6% | 2145 |
| Belgium | 4.1% | 31.6% | 23.1% | 29.7% | 11.4% | 1763 |
| Switzerland | 1.8% | 26.4% | 18.5% | 42.5% | 10.9% | 2124 |
| Czech Republic | 3.5% | 16.0% | 27.3% | 29.5% | 23.7% | 2877 |
| Germany | 1.6% | 18.4% | 23.7% | 45.7% | 10.6% | 2833 |
| Denmark | 2.0% | 21.4% | 17.4% | 42.5% | 16.7% | 1464 |
| Estonia | 1.4% | 19.8% | 27.1% | 42.1% | 9.6% | 1889 |
| Spain | 1.7% | 18.2% | 19.0% | 45.8% | 15.4% | 1628 |
| Finland | 2.8% | 16.4% | 17.3% | 42.6% | 21.1% | 2000 |
| France | 3.4% | 16.8% | 16.1% | 33.8% | 29.9% | 1803 |
| United Kingdom | 1.1% | 14.3% | 17.6% | 52.6% | 14.5% | 1887 |
| Greece | 2.4% | 12.4% | 22.6% | 46.1% | 16.5% | 2340 |
| Hungary | 2.4% | 16.3% | 25.3% | 42.4% | 13.6% | 1473 |
| Ireland | 1.7% | 15.3% | 12.1% | 60.7% | 10.2% | 2264 |
| Iceland | .5% | 15.5% | 16.1% | 54.1% | 13.8% | 560 |
| Luxembourg | 3.9% | 21.5% | 20.6% | 39.0% | 14.9% | 1598 |
| Netherlands | 2.4% | 31.6% | 24.1% | 36.2% | 5.7% | 1866 |
| Norway | .9% | 16.3% | 17.7% | 49.8% | 15.3% | 1756 |
| Poland | 3.2% | 23.5% | 23.5% | 40.4% | 9.4% | 1652 |
| Portugal | 1.1% | 10.8% | 25.1% | 42.7% | 20.3% | 1992 |
| Sweden | 1.1% | 18.2% | 18.9% | 45.2% | 16.6% | 1930 |
| Slovenia | 3.3% | 14.8% | 27.8% | 43.2% | 10.9% | 1395 |
| Slovakia | 1.0% | 15.2% | 27.9% | 48.2% | 7.7% | 1451 |
| Turkey | 3.0% | 8.9% | 11.6% | 55.7% | 20.8% | 1772 |
| Ukraine | 3.9% | 12.6% | 24.2% | 40.0% | 19.2% | 1907 |
| Total | 2.4% | 18.3% | 21.4% | 42.7% | 15.2% | 46369 |

| | Occasionally alright to ignore law and do what you want | | | | | Total |
|--------|---|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Male | 2.8% | 20.9% | 22.3% | 40.2% | 13.8% | 21356 |
| Female | 2.0% | 16.1% | 20.6% | 44.9% | 16.4% | 24943 |
| Total | 2.4% | 18.3% | 21.4% | 42.7% | 15.2% | 46299 |

| | Occasionally alright to ignore law and do what you want | | | | | Total |
|--------------|---|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| 24 and under | 2.7% | 22.5% | 26.7% | 37.9% | 10.3% | 6443 |
| 25-34 | 2.4% | 19.0% | 24.1% | 42.0% | 12.5% | 7394 |
| 35-44 | 2.3% | 18.8% | 22.3% | 42.2% | 14.4% | 8439 |
| 45-54 | 2.4% | 18.7% | 21.1% | 42.9% | 14.8% | 7839 |
| 55-64 | 2.4% | 18.5% | 18.0% | 43.7% | 17.3% | 7026 |
| 65-74 | 1.9% | 14.4% | 17.6% | 46.5% | 19.5% | 5532 |
| 75 and over | 2.2% | 13.1% | 16.6% | 46.5% | 21.7% | 3451 |
| Total | 2.3% | 18.3% | 21.4% | 42.8% | 15.2% | 46124 |

| | Citizens should spend some free time helping others | | | | | Total |
|----------------|---|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Austria | 17.5% | 52.0% | 22.3% | 5.6% | 2.5% | 2185 |
| Belgium | 16.5% | 48.2% | 23.5% | 10.4% | 1.4% | 1775 |
| Switzerland | 15.1% | 63.8% | 15.8% | 4.9% | .4% | 2136 |
| Czech Republic | 23.3% | 52.2% | 20.2% | 3.7% | .6% | 2930 |
| Germany | 11.2% | 63.5% | 20.1% | 4.7% | .5% | 2826 |
| Denmark | 10.3% | 50.9% | 26.8% | 9.9% | 2.1% | 1460 |
| Estonia | 9.5% | 52.6% | 29.9% | 7.0% | .9% | 1907 |
| Spain | 17.2% | 67.7% | 11.6% | 2.5% | 1.0% | 1646 |
| Finland | 12.2% | 51.4% | 28.6% | 7.0% | .8% | 2012 |
| France | 29.7% | 49.2% | 15.3% | 4.1% | 1.8% | 1803 |
| United Kingdom | 12.6% | 58.4% | 25.1% | 3.7% | .3% | 1890 |
| Greece | 24.1% | 60.0% | 11.8% | 3.2% | .9% | 2396 |
| Hungary | 18.7% | 56.2% | 17.1% | 6.5% | 1.6% | 1483 |
| Ireland | 21.2% | 67.2% | 8.3% | 3.1% | .3% | 2263 |
| Iceland | 13.1% | 52.1% | 27.6% | 6.7% | .5% | 566 |
| Luxembourg | 17.2% | 63.5% | 14.3% | 4.4% | .6% | 1612 |
| Netherlands | 7.8% | 45.8% | 25.6% | 19.4% | 1.4% | 1874 |
| Norway | 15.6% | 63.0% | 17.7% | 3.6% | .1% | 1759 |
| Poland | 13.1% | 66.1% | 17.1% | 3.6% | .2% | 1689 |
| Portugal | 27.9% | 60.5% | 10.4% | .8% | .3% | 2026 |
| Sweden | 7.4% | 60.7% | 27.6% | 4.0% | .3% | 1923 |
| Slovenia | 16.0% | 66.9% | 13.7% | 3.1% | .4% | 1427 |
| Slovakia | 12.6% | 66.5% | 18.0% | 2.6% | .2% | 1474 |
| Turkey | 46.3% | 47.2% | 4.0% | 1.8% | .8% | 1828 |
| Ukraine | 21.3% | 47.1% | 22.9% | 7.6% | 1.2% | 1969 |
| Total | 17.8% | 57.3% | 18.8% | 5.2% | .8% | 46859 |

| | Citizens should spend some free time helping others | | | | | Total |
|--------|---|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Male | 16.8% | 57.7% | 19.1% | 5.5% | .9% | 21514 |
| Female | 18.7% | 57.0% | 18.5% | 5.0% | .8% | 25275 |
| Total | 17.8% | 57.3% | 18.8% | 5.2% | .8% | 46789 |

| | Citizens should spend some free time helping others | | | | | Total |
|--------------|---|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| 24 and under | 16.5% | 57.8% | 20.6% | 4.3% | .8% | 6505 |
| 25-34 | 15.9% | 56.0% | 21.7% | 5.7% | .8% | 7449 |
| 35-44 | 16.3% | 55.3% | 21.2% | 6.3% | .8% | 8496 |
| 45-54 | 16.2% | 57.1% | 19.9% | 6.0% | .9% | 7888 |
| 55-64 | 18.7% | 58.6% | 16.4% | 5.3% | 1.0% | 7075 |
| 65-74 | 21.0% | 60.1% | 14.1% | 4.1% | .8% | 5637 |
| 75 and over | 24.6% | 58.6% | 12.7% | 3.4% | .8% | 3555 |
| Total | 17.8% | 57.4% | 18.7% | 5.2% | .8% | 46605 |

| | Citizens should not cheat on taxes | | | | | Total |
|----------------|------------------------------------|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Austria | 31.8% | 39.5% | 19.4% | 6.4% | 3.0% | 2149 |
| Belgium | 19.2% | 41.1% | 21.6% | 14.3% | 3.7% | 1762 |
| Switzerland | 28.4% | 54.0% | 10.3% | 5.7% | 1.6% | 2121 |
| Czech Republic | 46.8% | 31.1% | 12.2% | 4.2% | 5.7% | 2901 |
| Germany | 17.5% | 56.2% | 17.0% | 7.6% | 1.8% | 2794 |
| Denmark | 35.4% | 47.3% | 10.7% | 4.9% | 1.7% | 1475 |
| Estonia | 27.9% | 61.8% | 7.3% | 2.1% | .9% | 1937 |
| Spain | 20.8% | 60.9% | 10.1% | 5.5% | 2.7% | 1640 |
| Finland | 37.7% | 44.0% | 11.8% | 4.8% | 1.8% | 2013 |
| France | 39.6% | 37.2% | 13.8% | 6.3% | 3.2% | 1800 |
| United Kingdom | 22.5% | 58.4% | 11.8% | 5.3% | 1.9% | 1891 |
| Greece | 28.4% | 47.6% | 14.6% | 7.2% | 2.1% | 2366 |
| Hungary | 37.5% | 48.7% | 8.7% | 3.6% | 1.5% | 1477 |
| Ireland | 27.8% | 59.5% | 7.2% | 4.5% | 1.0% | 2267 |
| Iceland | 30.5% | 54.7% | 10.2% | 3.4% | 1.2% | 567 |
| Luxembourg | 31.1% | 49.1% | 10.1% | 6.1% | 3.5% | 1554 |
| Netherlands | 20.0% | 61.8% | 10.3% | 6.7% | 1.2% | 1870 |
| Norway | 21.9% | 59.3% | 10.9% | 6.5% | 1.4% | 1756 |
| Poland | 26.3% | 59.9% | 10.1% | 3.1% | .6% | 1699 |
| Portugal | 35.1% | 50.3% | 12.0% | 1.7% | .9% | 2011 |
| Sweden | 27.3% | 51.1% | 10.2% | 7.4% | 4.0% | 1936 |
| Slovenia | 31.6% | 52.3% | 10.1% | 4.7% | 1.3% | 1416 |
| Slovakia | 23.8% | 57.8% | 8.7% | 6.9% | 2.7% | 1472 |
| Turkey | 58.2% | 36.0% | 2.2% | 1.6% | 2.1% | 1798 |
| Ukraine | 34.3% | 34.0% | 22.0% | 7.2% | 2.5% | 1899 |
| Total | 30.5% | 49.6% | 12.0% | 5.6% | 2.3% | 46571 |

| | Citizens should not cheat on taxes | | | | | Total |
|--------|------------------------------------|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Male | 27.9% | 49.7% | 13.4% | 6.5% | 2.5% | 21405 |
| Female | 32.8% | 49.5% | 10.9% | 4.8% | 2.1% | 25095 |
| Total | 30.5% | 49.6% | 12.0% | 5.6% | 2.3% | 46500 |

| | Citizens should not cheat on taxes | | | | | Total |
|--------------|------------------------------------|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| 24 and under | 25.6% | 51.2% | 14.8% | 6.0% | 2.3% | 6392 |
| 25-34 | 27.3% | 50.1% | 14.4% | 6.2% | 2.0% | 7424 |
| 35-44 | 27.2% | 50.6% | 13.4% | 6.7% | 2.1% | 8486 |
| 45-54 | 29.2% | 50.4% | 12.1% | 5.8% | 2.6% | 7869 |
| 55-64 | 33.9% | 49.2% | 9.9% | 4.9% | 2.1% | 7050 |
| 65-74 | 36.9% | 48.4% | 7.8% | 4.4% | 2.5% | 5575 |
| 75 and over | 40.3% | 44.8% | 8.8% | 3.7% | 2.4% | 3523 |
| Total | 30.5% | 49.6% | 12.0% | 5.6% | 2.3% | 46319 |

| | You should always obey law even if it means missing good opportunities | | | | | Total |
|----------------|--|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Austria | 13.9% | 37.4% | 31.0% | 14.7% | 3.0% | 2147 |
| Belgium | 11.1% | 36.4% | 27.6% | 21.4% | 3.5% | 1765 |
| Switzerland | 13.6% | 50.8% | 21.7% | 12.7% | 1.3% | 2125 |
| Czech Republic | 25.0% | 39.8% | 22.6% | 9.1% | 3.5% | 2905 |
| Germany | 11.5% | 54.2% | 24.7% | 8.6% | .9% | 2837 |
| Denmark | 20.9% | 48.5% | 18.4% | 11.0% | 1.2% | 1463 |
| Estonia | 11.8% | 53.8% | 23.3% | 10.0% | 1.2% | 1909 |
| Spain | 11.2% | 53.9% | 22.2% | 10.2% | 2.4% | 1619 |
| Finland | 26.1% | 43.4% | 19.5% | 9.5% | 1.4% | 2005 |
| France | 31.1% | 39.0% | 16.2% | 11.1% | 2.7% | 1800 |
| United Kingdom | 14.2% | 53.7% | 20.9% | 10.2% | 1.0% | 1881 |
| Greece | 20.0% | 54.2% | 18.4% | 6.2% | 1.1% | 2342 |
| Hungary | 18.8% | 47.3% | 24.0% | 8.7% | 1.1% | 1475 |
| Ireland | 12.1% | 64.0% | 13.0% | 10.3% | .7% | 2262 |
| Iceland | 14.0% | 51.0% | 21.8% | 11.6% | 1.6% | 559 |
| Luxembourg | 17.6% | 50.5% | 18.7% | 10.8% | 2.3% | 1615 |
| Netherlands | 5.5% | 38.9% | 31.9% | 21.9% | 1.9% | 1861 |
| Norway | 15.4% | 59.4% | 16.6% | 7.4% | 1.2% | 1755 |
| Poland | 15.9% | 51.5% | 22.6% | 8.9% | 1.1% | 1681 |
| Portugal | 20.7% | 49.9% | 20.9% | 7.0% | 1.5% | 2005 |
| Sweden | 14.2% | 49.4% | 25.0% | 10.3% | 1.1% | 1920 |
| Slovenia | 9.0% | 43.3% | 31.5% | 14.3% | 1.8% | 1408 |
| Slovakia | 8.6% | 48.7% | 29.1% | 12.8% | .8% | 1452 |
| Turkey | 38.7% | 44.7% | 9.9% | 4.5% | 2.2% | 1789 |
| Ukraine | 23.2% | 36.5% | 29.1% | 9.5% | 1.6% | 1940 |
| Total | 17.2% | 48.0% | 22.4% | 10.7% | 1.7% | 46520 |

| | You should always obey law even if it means missing good opportunities | | | | | Total |
|--------|--|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| Male | 15.8% | 46.2% | 23.9% | 12.1% | 2.0% | 21405 |
| Female | 18.4% | 49.5% | 21.0% | 9.6% | 1.5% | 25047 |
| Total | 17.2% | 48.0% | 22.4% | 10.7% | 1.7% | 46452 |

| | You should always obey law even if it means missing good opportunities | | | | | Total |
|--------------|--|-------|----------------------------|----------|-------------------|-------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly | |
| 24 and under | 12.1% | 42.3% | 28.5% | 15.2% | 1.9% | 6480 |
| 25-34 | 13.2% | 45.8% | 26.3% | 13.1% | 1.6% | 7413 |
| 35-44 | 14.8% | 47.0% | 24.7% | 11.7% | 1.8% | 8445 |
| 45-54 | 16.6% | 49.2% | 22.4% | 10.2% | 1.6% | 7855 |
| 55-64 | 20.2% | 50.4% | 19.0% | 8.8% | 1.6% | 7037 |
| 65-74 | 23.1% | 52.6% | 15.6% | 6.9% | 1.8% | 5556 |
| 75 and over | 26.8% | 50.8% | 14.1% | 6.6% | 1.7% | 3486 |
| Total | 17.2% | 48.0% | 22.3% | 10.7% | 1.7% | 46272 |

| | Most people try to take advantage of me | Most people try to take advantage of you, or try to be fair | | | | | | | | | | Total |
|----------------|---|---|-------|-------|-------|-------|-------|-------|-------|-------|----------------------------|-------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Most people try to be fair | |
| Austria | 2.4% | 2.0% | 3.8% | 7.2% | 9.1% | 21.7% | 11.2% | 17.5% | 15.4% | 5.2% | 4.4% | 2221 |
| Belgium | 2.7% | 1.4% | 5.1% | 7.6% | 8.4% | 22.6% | 12.1% | 22.2% | 12.6% | 2.9% | 2.5% | 1772 |
| Switzerland | .9% | 1.2% | 2.4% | 4.6% | 5.8% | 18.0% | 10.6% | 21.6% | 24.1% | 6.6% | 4.3% | 2134 |
| Czech Republic | 4.3% | 2.8% | 5.8% | 9.5% | 11.8% | 23.0% | 12.0% | 14.5% | 11.4% | 3.3% | 1.6% | 2965 |
| Germany | 2.5% | 1.3% | 4.5% | 7.4% | 8.9% | 21.6% | 12.7% | 18.4% | 15.8% | 4.0% | 2.9% | 2853 |
| Denmark | .6% | .5% | 1.3% | 2.2% | 3.3% | 12.8% | 6.1% | 16.5% | 29.4% | 16.1% | 11.1% | 1475 |
| Estonia | 1.8% | 2.3% | 5.6% | 10.6% | 9.4% | 24.1% | 10.8% | 16.7% | 12.2% | 3.6% | 2.9% | 1942 |
| Spain | 3.4% | 2.8% | 7.4% | 7.4% | 8.6% | 25.8% | 14.1% | 16.6% | 10.0% | 2.1% | 1.8% | 1656 |
| Finland | .4% | .7% | 1.3% | 3.2% | 3.8% | 12.3% | 11.5% | 25.0% | 29.7% | 9.1% | 2.9% | 2013 |
| France | 3.3% | 1.7% | 4.2% | 6.2% | 8.5% | 25.9% | 12.6% | 16.6% | 14.5% | 3.8% | 2.8% | 1804 |
| United Kingdom | 1.4% | 2.0% | 4.5% | 8.9% | 9.8% | 23.8% | 12.7% | 18.7% | 13.1% | 3.2% | 1.7% | 1883 |
| Greece | 6.4% | 12.1% | 13.8% | 15.4% | 12.0% | 20.3% | 8.3% | 6.6% | 3.6% | 1.1% | .4% | 2404 |
| Hungary | 5.1% | 5.7% | 10.1% | 12.3% | 11.3% | 23.6% | 9.6% | 10.7% | 8.4% | 1.3% | 1.9% | 1485 |
| Ireland | 1.5% | 3.9% | 4.0% | 6.1% | 7.1% | 16.9% | 10.1% | 18.5% | 19.9% | 7.9% | 4.3% | 2278 |
| Iceland | .4% | .2% | 1.4% | 3.3% | 4.2% | 14.3% | 9.2% | 22.0% | 31.2% | 8.3% | 5.6% | 568 |
| Luxembourg | 4.1% | 2.2% | 5.3% | 7.4% | 7.4% | 23.3% | 9.1% | 12.6% | 16.6% | 6.8% | 5.3% | 1619 |
| Netherlands | .9% | 1.2% | 2.1% | 3.8% | 6.4% | 15.5% | 16.5% | 30.7% | 17.5% | 4.3% | 1.1% | 1878 |
| Norway | .3% | .6% | 1.5% | 3.3% | 3.2% | 12.6% | 10.2% | 24.6% | 28.5% | 9.7% | 5.4% | 1759 |
| Poland | 6.8% | 5.9% | 8.7% | 12.8% | 10.2% | 25.3% | 6.4% | 9.4% | 8.4% | 3.1% | 3.0% | 1674 |
| Portugal | 1.7% | 2.5% | 8.5% | 14.9% | 14.7% | 23.6% | 12.9% | 11.3% | 6.4% | 2.2% | 1.4% | 2033 |
| Sweden | .9% | .9% | 3.0% | 4.4% | 5.1% | 16.3% | 10.4% | 20.8% | 24.6% | 9.9% | 3.7% | 1938 |
| Slovenia | 5.9% | 4.5% | 9.2% | 11.5% | 8.7% | 25.9% | 7.6% | 11.2% | 10.9% | 2.7% | 2.0% | 1432 |
| Slovakia | 6.6% | 4.2% | 7.5% | 12.4% | 13.3% | 30.0% | 7.9% | 8.3% | 6.0% | 1.5% | 2.4% | 1479 |
| Turkey | 16.0% | 14.2% | 11.4% | 10.6% | 7.5% | 15.5% | 6.7% | 5.5% | 5.3% | 2.5% | 4.8% | 1822 |
| Ukraine | 5.2% | 4.6% | 8.2% | 13.5% | 10.0% | 26.6% | 8.9% | 10.4% | 5.8% | 2.3% | 4.5% | 1970 |
| Total | 3.4% | 3.3% | 5.7% | 8.4% | 8.6% | 20.9% | 10.6% | 16.3% | 14.8% | 4.8% | 3.2% | 47057 |

| | Most people try to take advantage of you, or try to be fair | | | | | | | | | | | Total |
|--------|---|------|------|------|------|-------|-------|-------|-------|------|----------------------------|-------|
| | Most people try to take advantage of me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Most people try to be fair | |
| Male | 3.6% | 3.2% | 5.8% | 8.7% | 8.4% | 21.2% | 11.0% | 16.8% | 14.3% | 4.4% | 2.7% | 21634 |
| Female | 3.3% | 3.5% | 5.6% | 8.2% | 8.7% | 20.6% | 10.3% | 15.8% | 15.2% | 5.1% | 3.6% | 25347 |
| Total | 3.4% | 3.3% | 5.7% | 8.4% | 8.6% | 20.9% | 10.6% | 16.3% | 14.8% | 4.8% | 3.2% | 46981 |

| | Most people try to take advantage of you, or try to be fair | | | | | | | | | | | Total |
|--------------|---|------|------|------|------|-------|-------|-------|-------|------|----------------------------|-------|
| | Most people try to take advantage of me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Most people try to be fair | |
| 24 and under | 2.5% | 3.0% | 4.7% | 8.3% | 9.7% | 22.2% | 12.5% | 17.0% | 13.0% | 4.5% | 2.6% | 6536 |
| 25-34 | 3.9% | 3.5% | 6.1% | 8.3% | 9.2% | 21.5% | 11.6% | 17.0% | 13.0% | 4.0% | 1.9% | 7478 |
| 35-44 | 3.6% | 3.4% | 5.1% | 8.1% | 8.1% | 20.9% | 11.4% | 17.7% | 14.5% | 4.5% | 2.6% | 8524 |
| 45-54 | 3.6% | 3.0% | 5.6% | 8.5% | 8.0% | 20.5% | 10.1% | 16.6% | 16.2% | 4.8% | 3.0% | 7920 |
| 55-64 | 3.6% | 3.4% | 5.5% | 7.8% | 8.2% | 21.2% | 10.0% | 15.2% | 16.5% | 5.1% | 3.6% | 7108 |
| 65-74 | 3.3% | 3.5% | 7.3% | 9.6% | 8.6% | 19.3% | 8.8% | 15.1% | 14.6% | 5.3% | 4.6% | 5642 |
| 75 and over | 2.9% | 4.0% | 6.3% | 8.5% | 7.6% | 19.8% | 8.3% | 13.6% | 16.6% | 6.1% | 6.3% | 3586 |
| Total | 3.4% | 3.3% | 5.7% | 8.4% | 8.5% | 20.9% | 10.6% | 16.3% | 14.8% | 4.8% | 3.2% | 46794 |

| | Most people can be trusted or you can't be too careful | | | | | | | | | | | Total |
|----------------|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|----------------------------|-------|
| | You can't be too careful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Most people can be trusted | |
| Austria | 5.8% | 3.4% | 5.1% | 9.1% | 10.5% | 23.0% | 11.7% | 16.2% | 10.0% | 2.8% | 2.5% | 2234 |
| Belgium | 7.3% | 3.3% | 6.9% | 11.1% | 9.2% | 22.5% | 12.2% | 17.5% | 7.6% | 1.4% | 1.1% | 1776 |
| Switzerland | 2.5% | 1.3% | 4.3% | 9.1% | 7.7% | 22.0% | 11.1% | 19.0% | 17.4% | 3.8% | 1.9% | 2141 |
| Czech Republic | 8.4% | 6.7% | 11.0% | 15.0% | 11.8% | 18.9% | 9.1% | 10.4% | 5.9% | 1.9% | 1.0% | 2994 |
| Germany | 5.9% | 2.7% | 8.3% | 13.0% | 12.1% | 21.6% | 10.7% | 14.3% | 8.3% | 2.0% | 1.2% | 2866 |
| Denmark | 1.6% | 1.3% | 1.7% | 4.2% | 3.8% | 15.4% | 8.1% | 18.7% | 27.7% | 10.9% | 6.7% | 1478 |
| Estonia | 2.1% | 3.5% | 5.7% | 9.9% | 10.5% | 25.7% | 13.6% | 16.1% | 9.1% | 2.1% | 1.7% | 1970 |
| Spain | 5.4% | 3.6% | 6.9% | 9.3% | 9.6% | 25.6% | 14.4% | 14.1% | 8.8% | .9% | 1.3% | 1661 |
| Finland | .5% | .4% | 1.8% | 4.6% | 5.8% | 15.0% | 13.2% | 23.5% | 26.8% | 5.7% | 2.6% | 2015 |
| France | 6.7% | 4.0% | 8.2% | 11.6% | 12.9% | 27.4% | 8.8% | 10.6% | 7.1% | 1.6% | 1.0% | 1805 |
| United Kingdom | 3.5% | 3.2% | 5.0% | 10.2% | 12.3% | 23.9% | 12.0% | 15.3% | 11.1% | 2.5% | 1.1% | 1893 |
| Greece | 7.8% | 10.8% | 14.1% | 14.2% | 11.0% | 17.9% | 7.2% | 8.1% | 5.8% | 2.4% | .7% | 2405 |
| Hungary | 7.7% | 7.1% | 12.3% | 15.0% | 11.3% | 24.2% | 8.4% | 7.2% | 4.8% | .6% | 1.3% | 1490 |
| Ireland | 2.5% | 2.6% | 4.5% | 7.4% | 7.6% | 18.1% | 11.5% | 16.8% | 17.3% | 7.1% | 4.6% | 2278 |
| Iceland | 3.7% | .7% | 2.8% | 4.9% | 5.1% | 14.0% | 8.2% | 26.5% | 20.7% | 8.6% | 4.7% | 570 |
| Luxembourg | 7.0% | 3.5% | 4.7% | 10.9% | 8.5% | 26.5% | 9.3% | 12.9% | 10.7% | 3.1% | 2.9% | 1629 |
| Netherlands | 2.4% | 1.6% | 3.3% | 7.3% | 7.5% | 15.9% | 16.1% | 27.7% | 14.8% | 2.7% | .9% | 1880 |
| Norway | .8% | .9% | 1.9% | 4.3% | 4.5% | 14.4% | 11.0% | 22.8% | 28.2% | 7.8% | 3.4% | 1758 |
| Poland | 13.0% | 9.3% | 11.5% | 14.7% | 11.1% | 22.2% | 6.8% | 5.7% | 4.1% | .8% | .8% | 1707 |
| Portugal | 6.7% | 6.5% | 13.7% | 19.0% | 15.2% | 17.6% | 8.3% | 7.9% | 3.2% | 1.1% | .8% | 2049 |
| Sweden | 2.7% | 1.4% | 4.0% | 6.7% | 7.4% | 16.7% | 8.9% | 21.3% | 21.2% | 7.2% | 2.7% | 1941 |
| Slovenia | 9.6% | 7.2% | 11.2% | 13.6% | 9.6% | 21.1% | 7.7% | 10.3% | 7.4% | 1.5% | .9% | 1437 |
| Slovakia | 10.7% | 5.9% | 9.1% | 12.5% | 11.9% | 30.2% | 6.7% | 7.1% | 3.3% | 1.1% | 1.6% | 1498 |
| Turkey | 23.9% | 16.6% | 10.3% | 9.8% | 6.5% | 16.2% | 4.1% | 5.1% | 4.2% | .6% | 2.8% | 1840 |
| Ukraine | 10.1% | 6.1% | 9.4% | 13.0% | 10.6% | 22.6% | 8.0% | 7.2% | 5.9% | 2.9% | 4.2% | 2013 |
| Total | 6.3% | 4.6% | 7.3% | 10.7% | 9.6% | 20.7% | 10.0% | 14.2% | 11.3% | 3.1% | 2.0% | 47328 |

| | Most people can be trusted or you can't be too careful | | | | | | | | | | | Total |
|--------|--|------|------|-------|------|-------|-------|-------|-------|------|----------------------------|-------|
| | You can't be too careful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Most people can be trusted | |
| Male | 6.0% | 4.3% | 7.0% | 10.5% | 9.3% | 20.4% | 10.5% | 15.2% | 11.7% | 3.0% | 1.9% | 21721 |
| Female | 6.6% | 5.0% | 7.6% | 10.9% | 9.9% | 21.0% | 9.6% | 13.3% | 10.9% | 3.2% | 2.2% | 25529 |
| Total | 6.3% | 4.6% | 7.3% | 10.7% | 9.6% | 20.7% | 10.0% | 14.2% | 11.3% | 3.1% | 2.0% | 47250 |

| | Most people can be trusted or you can't be too careful | | | | | | | | | | | Total |
|--------------|--|------|------|-------|-------|-------|-------|-------|-------|------|----------------------------|-------|
| | You can't be too careful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Most people can be trusted | |
| 24 and under | 4.8% | 3.6% | 6.3% | 10.3% | 11.9% | 22.0% | 12.2% | 15.8% | 9.4% | 2.3% | 1.4% | 6568 |
| 25-34 | 5.9% | 5.0% | 7.3% | 11.2% | 10.0% | 20.7% | 10.6% | 15.3% | 10.1% | 2.4% | 1.6% | 7515 |
| 35-44 | 6.2% | 4.4% | 7.0% | 10.4% | 9.2% | 20.0% | 10.5% | 15.3% | 12.1% | 3.1% | 1.8% | 8565 |
| 45-54 | 6.5% | 4.4% | 7.1% | 10.3% | 9.6% | 19.5% | 9.4% | 14.6% | 13.0% | 3.4% | 2.3% | 7952 |
| 55-64 | 6.6% | 4.7% | 7.3% | 10.3% | 8.9% | 21.3% | 9.3% | 13.6% | 12.0% | 3.6% | 2.4% | 7143 |
| 65-74 | 7.4% | 5.2% | 8.7% | 11.6% | 8.8% | 21.3% | 8.7% | 11.8% | 10.5% | 3.7% | 2.4% | 5689 |
| 75 and over | 7.2% | 6.0% | 8.0% | 11.6% | 8.5% | 20.8% | 8.3% | 10.5% | 11.6% | 4.3% | 3.2% | 3626 |
| Total | 6.3% | 4.6% | 7.3% | 10.7% | 9.6% | 20.7% | 10.0% | 14.2% | 11.3% | 3.2% | 2.1% | 47058 |

| | Most of the time people helpful or mostly looking out for themselves | | | | | | | | | | | Total |
|----------------|--|-------|-------|-------|-------|-------|-------|-------|-------|------|---------------------------------|-------|
| | People mostly look out for themselves | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | People mostly try to be helpful | |
| Austria | 2.6% | 3.6% | 5.7% | 10.3% | 11.8% | 22.2% | 13.3% | 14.3% | 9.8% | 2.7% | 3.7% | 2233 |
| Belgium | 5.4% | 4.5% | 10.7% | 13.1% | 13.2% | 22.6% | 11.4% | 12.2% | 4.8% | 1.2% | .8% | 1774 |
| Switzerland | 1.1% | 1.7% | 5.0% | 10.6% | 9.4% | 25.0% | 12.4% | 17.2% | 13.1% | 2.8% | 1.7% | 2137 |
| Czech Republic | 6.9% | 8.3% | 12.5% | 14.8% | 13.0% | 18.5% | 9.2% | 8.1% | 5.9% | 1.6% | 1.0% | 2985 |
| Germany | 3.7% | 3.1% | 7.4% | 13.8% | 14.3% | 23.2% | 12.3% | 11.8% | 7.5% | 1.9% | 1.1% | 2862 |
| Denmark | 1.1% | 1.6% | 3.0% | 6.8% | 7.1% | 23.9% | 11.5% | 16.9% | 17.9% | 6.6% | 3.6% | 1483 |
| Estonia | 2.8% | 4.2% | 7.9% | 14.1% | 11.8% | 27.3% | 10.4% | 10.6% | 7.2% | 2.3% | 1.1% | 1968 |
| Spain | 7.0% | 6.1% | 13.2% | 13.6% | 11.3% | 19.6% | 12.1% | 9.4% | 5.8% | 1.2% | .7% | 1661 |
| Finland | 0.7% | 1.1% | 3.1% | 9.3% | 11.8% | 19.0% | 16.0% | 20.0% | 13.6% | 3.6% | 1.5% | 2015 |
| France | 4.4% | 4.1% | 7.8% | 15.5% | 13.0% | 24.8% | 10.1% | 10.9% | 6.1% | 1.4% | 1.7% | 1801 |
| United Kingdom | 1.4% | 1.6% | 3.6% | 8.4% | 9.6% | 23.4% | 14.0% | 18.7% | 13.8% | 3.4% | 2.1% | 1888 |
| Greece | 8.9% | 17.0% | 17.0% | 15.4% | 11.1% | 14.6% | 6.9% | 4.8% | 3.3% | .6% | .4% | 2396 |
| Hungary | 6.1% | 8.2% | 12.6% | 15.6% | 11.7% | 22.6% | 8.7% | 7.2% | 5.0% | 1.0% | 1.3% | 1489 |
| Ireland | 1.6% | 1.7% | 2.9% | 6.2% | 5.8% | 17.0% | 10.8% | 20.3% | 20.3% | 9.0% | 4.4% | 2270 |
| Iceland | 0.4% | 1.4% | 2.1% | 5.3% | 6.7% | 22.5% | 14.2% | 18.1% | 19.6% | 5.4% | 4.4% | 570 |
| Luxembourg | 5.6% | 3.8% | 7.6% | 12.7% | 10.2% | 26.2% | 10.0% | 11.1% | 7.2% | 2.8% | 2.8% | 1617 |
| Netherlands | 1.2% | 1.9% | 5.6% | 8.3% | 11.7% | 21.4% | 19.1% | 19.1% | 8.8% | 2.2% | .6% | 1881 |
| Norway | 0.8% | 0.8% | 2.9% | 6.9% | 8.4% | 21.0% | 15.8% | 20.1% | 15.1% | 4.7% | 3.5% | 1759 |
| Poland | 15.7% | 12.4% | 13.8% | 16.3% | 9.8% | 18.1% | 4.4% | 4.1% | 3.2% | .9% | 1.2% | 1706 |
| Portugal | 4.6% | 6.1% | 15.9% | 18.7% | 17.1% | 18.4% | 7.7% | 7.5% | 3.0% | .6% | .4% | 2031 |
| Sweden | 0.9% | 1.4% | 4.0% | 6.7% | 8.9% | 21.3% | 13.5% | 18.0% | 17.3% | 5.2% | 2.7% | 1941 |
| Slovenia | 7.0% | 5.8% | 11.9% | 13.1% | 8.9% | 24.2% | 8.1% | 10.5% | 7.7% | 1.6% | 1.3% | 1432 |
| Slovakia | 11.6% | 8.2% | 11.4% | 15.1% | 13.8% | 21.8% | 6.1% | 5.7% | 3.5% | .6% | 2.2% | 1496 |
| Turkey | 19.1% | 14.1% | 12.1% | 10.1% | 7.6% | 14.7% | 5.0% | 5.8% | 4.9% | 2.7% | 3.9% | 1836 |
| Ukraine | 10.8% | 9.1% | 12.9% | 15.2% | 10.2% | 19.7% | 7.7% | 6.3% | 3.5% | 1.5% | 3.1% | 1996 |
| Total | 5.3% | 5.4% | 8.7% | 12.1% | 11.0% | 21.1% | 10.8% | 12.2% | 8.8% | 2.6% | 1.9% | 47227 |

| | Most of the time people helpful or mostly looking out for themselves | | | | | | | | | | | Total |
|--------|--|------|------|-------|-------|-------|-------|-------|------|------|---------------------------------|-------|
| | People mostly look out for themselves | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | People mostly try to be helpful | |
| Male | 5.4% | 5.4% | 8.9% | 12.3% | 11.0% | 21.1% | 11.1% | 12.5% | 8.4% | 2.3% | 1.5% | 21684 |
| Female | 5.1% | 5.5% | 8.5% | 11.9% | 10.9% | 21.0% | 10.6% | 12.0% | 9.2% | 2.9% | 2.3% | 25467 |
| Total | 5.3% | 5.4% | 8.7% | 12.1% | 11.0% | 21.1% | 10.8% | 12.2% | 8.8% | 2.6% | 1.9% | 47151 |

| | Most of the time people helpful or mostly looking out for themselves | | | | | | | | | | | Total |
|--------------|--|------|------|-------|-------|-------|-------|-------|-------|------|---------------------------------|-------|
| | People mostly look out for themselves | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | People mostly try to be helpful | |
| 24 and under | 4.7% | 4.4% | 8.2% | 11.8% | 13.3% | 22.3% | 11.7% | 12.2% | 7.2% | 2.4% | 1.8% | 6566 |
| 25-34 | 5.7% | 6.0% | 8.8% | 12.7% | 11.7% | 21.7% | 11.3% | 11.7% | 7.2% | 1.7% | 1.4% | 7490 |
| 35-44 | 5.1% | 5.4% | 7.9% | 12.0% | 10.9% | 21.5% | 11.9% | 13.2% | 8.7% | 2.0% | 1.4% | 8559 |
| 45-54 | 5.5% | 5.5% | 8.8% | 12.3% | 10.4% | 20.7% | 11.2% | 12.6% | 8.9% | 2.6% | 1.5% | 7938 |
| 55-64 | 5.4% | 5.4% | 8.7% | 12.2% | 10.7% | 20.8% | 10.1% | 12.1% | 9.3% | 3.1% | 2.1% | 7126 |
| 65-74 | 5.3% | 5.6% | 9.6% | 12.1% | 9.7% | 20.1% | 9.6% | 11.6% | 10.4% | 3.4% | 2.7% | 5666 |
| 75 and over | 4.4% | 5.8% | 9.5% | 10.7% | 9.0% | 19.6% | 8.2% | 11.6% | 12.4% | 4.6% | 4.2% | 3615 |
| Total | 5.2% | 5.4% | 8.7% | 12.1% | 11.0% | 21.1% | 10.8% | 12.2% | 8.9% | 2.6% | 2.0% | 46960 |

Appendix 4: Project related publications and relevant dissemination activities

Publications in peer reviewed journals

2004

Greco D, Petrini C. “Alcuni aspetti di etica in sanità pubblica” *Annali dell'Istituto Superiore di Sanità*, 2004; 40 (3):363-371.

Petrini C. “Ricerca biomedica e ricerca in sanità pubblica: alcune analogie e differenze operative e nei criteri di valutazione etica. (Parte prima)” *Biologi italiani* 2004; 34 (7):17-20.

Petrini C. “Ricerca biomedica e ricerca in sanità pubblica: alcune analogie e differenze operative e nei criteri di valutazione etica. (Parte seconda)” *Biologi italiani* 2004; 34 (8):9-12.

Scuderi G, Guidoni L, Rosmini F, Petrini C. “La normativa sulla protezione dei soggetti partecipanti a studi clinici in Italia: dagli anni” (Italian regulation on the protection of human subjects participating to clinical studies, from the Nineties to 2004) *Ann Ist Super Sanità* 2004; 40 (4):495-507.

Verweij M, Dawson A. “Ethical principles for collective immunization programmes” *Vaccine* 2004; 22:3122-6.

2005

Ashcroft RE. “Standing Up for the Medical Rights of Asylum Seekers” *J Med Ethics* 2005; 31:125-126.

Ashcroft RE. “Access to Essential Medicines: A Social Contract Approach” *Developing World Bioethics* 2005; 5(2):121-141.

Ashcroft RE. “Ethics Committees in Transition Countries: A Figleaf for Structural Violence?” *Br Med J* 2005; 331:229-230.

Ashcroft RE. “*Making Sense of Dignity*” (Essay review of Beyleveld D, Brownsword R Human Dignity in Bioethics and Biolaw Oxford: Oxford University Press, 2002, and Kass L Life, Liberty and the Defense of Dignity San Francisco: Encounter Books, 2002) *J Medical Ethics* 2005; 31:679-682.

Ashcroft RE, Newson AJ, Benn PMW. “Reforming Research Ethics Committees?” *Br Med J* 2005; 331:587-588.

Häyry M. “Precaution and solidarity” *Cambridge Quarterly of Healthcare Ethics* 2005; 14:199-206.

Häyry M. “Can arguments address concerns?” *J Med Ethics* 2005; 31:598-600.

Häyry M. “The tension between self-governance and absolute inner worth in Kant’s moral philosophy” *J Med Ethics* 2005; 31:645-647.

Majeed FA, Ashcroft RE. “Using children of asylum seekers and refugees as translators can create psychological problems for both parents and children” *NWLJGP* 2005; 11(1):5-6.

Petrini C. “Icune considerazioni sui principi della bioetica applicati alla sanità pubblica” (Parte prima: aspetti generali) *Biologi italiani* 2005; 35(10):41-48.

Petrini C. “Alcune considerazioni sui principi della bioetica applicati alla sanità pubblica” (Parte seconda: principilismo, personalismo e sanità pubblica) *Biologi italiani* 2005; 35 (11):13-19.

Shickle D, Piribauer F, Czabanowska K, Loewy EH. “Europhen Public Health Ethics Network- Europhen” 13th Annual EUPHA meeting, Promoting the Public Health: Reorienting Health policies, Linking Health Promotion and Health Care *European Journal of Public Health*,; 2005; 15(1):180.

Verweij M. “Obligatory precautions against infection” *Bioethics* 2005;19(4):323-335.

2006

Petrini C. “Etica della sanità pubblica: spunti da alcune “checklist””. *Biologi italiani* 2006; 36 (9): 18-22.

Häyry M. “Public health vs. human values” *Journal of Medical Ethics* 2006; 32: 519-521.

In Press

Griffin M, Shickle D, Moran N. “European Citizens Opinions on Water Fluoridation”. *Community Dentistry and Oral Epidemiology*, In Press.

Other publications in scientific journals or book chapters

2004

Petrini C. “L'etica della sanità pubblica in Europa: l'European” (Public Health Ethics Network) *Notiziario dell'Istituto Superiore di Sanità* 2004; 17 (3):8-11.

2005

Ashcroft RE. “Nothing to declare: UNESCO on ethics, human rights”
<http://www.scidev.net/opinions/index.cfm?fuseaction=readopinions&itemid=428&language=1> (9-9-2005).

Ashcroft RE. (unsigned) “Legislating to prevent exposure to environmental tobacco smoke in public places and workplaces: ethical and civil liberties arguments” in Tobacco Advisory Group of the Royal College of Physicians Going Smoke-Free: The Medical Case for Clean Air in the Home, at Work and in Public Places London: Royal College of Physicians, 2005. Ch.10, pp.115-128.

Petrini C. Le priorità di sanità pubblica in Europa tra etica e mercato. *Janus* 2005; 5 (17): 35-38.

Schüklenk U, Ashcroft RE. “Affordable access to essential medication in developing countries: Conflicts between ethical and economic imperatives” in Von Niekerk AA, Kopelman LM (eds.) *Ethics & AIDS in Africa: The Challenge to Our Thinking* Claremont (South Africa): David Philip Books, 2005: 127-14.

2006

Moran NE, Shickle D, Munthe C, Dierickx K, Petrini C, Piribauer F. *et al.* “Are Compulsory Immunisations and Incentives to Immunise Effective Ways to Achieve Herd Immunity in Europe?” In: Selgelid MJ, Battin MP, Smith CB (eds.). *Ethics and Infectious Disease*. Malden MA: Blackwell Publishing Ltd, 2006.

2007

Verweij M. “Ethics of public immunization programs” Kris Heggenhougen (ed.) *Encyclopedia of Public Health* Elsevier, 2007.

Juth, N, Munthe C. "Screening in Medicine: Ethical Aspects", in Aschcroft, RE, Dawson, A, Draper, H & McMillan J (eds.) *Principles of Health care Ethics*, 2nd Edition, Chichester: John Wiley & Sons, 2007.

In Press

Juth N, Munthe C. *The Ethics of Screening in Health Care*, Göteborg: Department of Philosophy, Göteborg University, In Press.

Verweij M. "Tobacco discouragement and the values of public health" Dawson A.J., Verweij M.F. (eds.) *Ethics, Prevention, and Public Health*. Oxford: OUP, In Press.

Verweij M. "What is 'public' in public health?" Dawson A.J., Verweij M.F. (eds.) *Ethics, Prevention, and Public Health*. Oxford: OUP, In Press.

Włodarczyk, Shickle D, Czabanowska K, Moran N (eds). . *Public Health in European Countries – Selected ethical problems*. Krakow: Jagiellonian University Press, In press.

International meeting abstracts, oral presentations, posters

2003

Shickle D. *The Problem of Balancing Private and Public Interest: Developing a European Framework for Public Health Ethics*. Riflessione etica e ricerca scientifica. Produzione e diffusione di risorse informative. Rome, 28 March 2003.

2004

Gylling H. *Paying for safety nets for the unlucky, the foolish, and the selfish*. UK Faculty of Public Health Annual Scientific Meeting, Edinburgh, June 2004.

Häyry M. *Arguments and Analysis in Bioethics*. Third North West Bioethics Roundtable (NorthWeb 3) meeting. Keele on 20 February 2004.

Kelleher K. *Ethics of Public Health practice* at the Royal College of Physicians of Ireland, Faculty of Public Health Medicine Summer Scientific Meeting. Dublin, 20-21 May 2004.

Munthe C. The Goals of Public Health and the Value of Autonomy, *Public Health 2004: Annual Scientific Meeting of the UK faculty of Public Health*, Edinburgh, June 8-10, 2004.

Munthe, C., Should Promotion of Autonomy be a Goal of Public Health?, *7th World Congress of the International Association of Bioethics*, Sydney, November, 2004.

Shickle D. *How do citizens of Europe perceive the trade-offs between private and public interest within public health policy?* UK Faculty of Public Health Annual Scientific Meeting, Edinburgh, June 2004.

Shickle D. *Ethics of Public Health practice* at the Royal College of Physicians of Ireland, Faculty of Public Health Medicine Summer Scientific Meeting. Dublin, 20-21 May 2004.

Shickle D. *How do European Citizens Trade-Off private and Public Interest within Public Health Policy*. Seventh World Congress of Bioethics, Sydney, Australia, 9-12 November 2004.

Verweij M. *Justifying paternalism towards adolescents*. Paper tijdens World Congress of Bioethics; International Association of Bioethics, Sydney. 12 November 2004.

Verweij M. Organization of the IAB/Interphen workshop *Liberty-limiting interventions during global outbreaks – A discussion on George Annas's human*

rights framework for public health ethics. Sydney, World Congress International Association of Bioethics. 9 November 2004.

Verweij M. *Paternalism and Tobacco Discouragement*. Invited paper at Society of Applied Philosophy Workshop “Public health, ethical theory, and public goods”. Gonville and Caius College, Cambridge University, Cambridge. 12 July 2004.

2005

Verweij M. *Ethical principles for collective immunization programmes*. Congreso Nacional de la Asociación de Vacunología, Madrid. 12 November 2005.

2006

Czabanowska K., Shickle D., Włodarczyk C. *Society, Community As Constructions Based On Social Capital (SC) And Sense Of Community (SoC) Theory*. 12th Qualitative Health Research Conference, Edmonton, Alberta, Canada, 2-5 April 2006.

Munthe C., *The Goals of Public Health and the Ethics of Public Health Policy*, *Ethics, Philosophy and Public Health*, Manchester, June 31-July 2, 2006.

Appendix 5: EuroPHEN Meetings

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|-----------|-------------|----------------------|
| Brussels | Belgium | 20-23 March 2003 |
| Barcelona | Spain | 6-9 November 2003 |
| Athens | Greece | 18-21 March 2004 |
| Edinburgh | UK | 11-13 June 2004 |
| Limerick | Ireland | 8-9 October 2004 |
| Rome | Italy | 21-24 April 2005 |
| Barcelona | Spain | 21-23 September 2005 |
| Hannover | Germany | 20-23 October 2005 |
| Krakow | Poland | 24-25 February 2006 |
| Amsterdam | Netherlands | 12-14 May 2006 |

References

- ¹ World Health Organisation. *Expert Committee on Public Health*. WHO, Geneva, 1952
- ² Acheson D. *Public health in England*. Department of Health, London, 1988
- ³ UK Faculty of Public Health. What is Public Health? [Accessed 7 September 2006] Available from: http://www.fph.org.uk/about_faculty/what_public_health/default.asp
- ⁴ Wanless D. *Securing good health for the whole population*. HM Treasury, London, 2004
- ⁵ Institute of Medicine. The future of public health, 1988. [Accessed 7 September 2006] Available from www.nap.edu
- ⁶ Public Health Service. *For a healthy nation: returns on investment in public health*. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion and CDC, 1994.
- ⁷ Fineberg HV. *The Harvard School of Public Health. Official Register of Harvard University 1992-3; 14* (9). Harvard School of Public Health, Boston, USA
- ⁸ Beaglehole R, Bonita R. *Public Health at the Crossroads*. Cambridge: Cambridge University Press, 1997.
- ⁹ Beaglehole R, Bonita R, Horton R, *et al*. Public Health in the new era: improving health through collective action. *Lancet* 2004;363: 2084-2086
- ¹⁰ General Medical Council. *The duties of a doctor registered with the General Medical Council*. London: general Medical Council, 2006. [Accessed 30 March 2007] Available from: http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp
- ¹¹ The Norwegian Medical Association. *Ethical rules for doctors*. (passed by the landsstyret in 1961 and amended in 2002. Available from <http://www.legeforeningen.no/index.gan?id=485>)
- ¹² German Medical Congress. *Code of Conduct for the Medical Profession in Germany* MBO Ä 1997. as amended in the resolutions of the 107th German Medical Congress in 2004
- ¹³ General Assembly of Physicians and Dentists. *Medical Code of Ethics passed at 3rd General Assembly of Physicians and Dentists on 12th-14th December 1993*, Warsaw. Available from: http://www.nil.org.pl/xml/nil/wladze/nil_eng/med_code
- ¹⁴ General Medical Council. *A Guide to Ethical Conduct and Behaviour*. General Medical Council: Dublin, 2004. [Accessed 30 March 2007] Available from: http://www.medicalcouncil.ie/_fileupload/standards/Ethical_Guide_6th_Edition.pdf
- ¹⁵ Nursing and Midwifery Council. *The NMC code of professional conduct: standards for conduct, performance and ethics*. London: Nursing and Midwifery Council, 2004. [Accessed 30 March 2007] Available from <http://www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=201>
- ¹⁶ American Medical Association. Principles of Ethics. Adopted by the AMA's House of Delegates June 17, 2001. [Accessed 4 August 2006] Available from: <http://www.ama-assn.org/ama/pub/category/2512>.

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- ¹⁷ American Bar Association. *Model Rules of Professional Conduct* (2004 Edition) Available from: http://www.abanet.org/cpr/mrpc/mrpc_toc.html
- ¹⁸ Public Health Leadership Society. *Principles of the Ethical Practice of Public Health*. New Orleans: Public Health Leadership Society, 2002. [Accessed 30 March 2007] Available from: <http://209.9.235.208/CMSuploads/PHLSposter-40152.pdf>
- ¹⁹ Public Health Leadership Society. *Principles of the Ethical Practice of Public Health*. New Orleans: Public Health Leadership Society, 2002. [Accessed 30 March 2007] Available from: <http://209.9.235.208/CMSuploads/PHLSethicsbrochure-40103.pdf>
- ²⁰ Treaty on European Union. OJ C340 10.11.97, pp 145-172
- ²¹ Proposal for a Programme of Community Action in the field of public health (2001-2006)'. Brussels 16.5.2000 COM [2000] 285 final
- ²² Samuelson PA, Nordhaus WD. *Economics*. 13th ed. New York: McGraw-Hill; 1989.
- ²³ Stuart Mill J. *Sobre la libertad*. Madrid: Alianza editorial; 1970.
- ²⁴ Rawls J. *Theory of Justice*. Cambridge, MA: Harvard University Press; 1971.
- ²⁵ Gargarella R. *Las teorías de justicia después de Rawls*. Barcelona: Paidós; 1999.
- ²⁶ Ovejero F, Martí JL. *Gargarella, compiladores. Nuevas ideas republicanas. Autogobierno y libertad*. Barcelona: Paidós; 2004.
- ²⁷ Gutmann A, Thompson D. *Democracy and disagreement*. Cambridge, MA: The Belknap Press of Harvard University Press, 1996
- ²⁸ Gutmann A, Thompson D. *Why deliberative democracy?* Princeton: Princeton University Press; 2004
- ²⁹ Daniels N. Accountability for reasonableness. *BMJ* 2000;321:1300-1.
- ³⁰ Conway D. *Classical Liberalism. The Unvanquished Ideal*. London: Macmillan, 1995, p. 137.
- ³¹ *Ibid* p. 26.
- ³² Gray J. *Beyond the New Right. Markets, Government and the Common Environment*. London and New York: Routledge, 1993, p. 4.
- ³³ Gray J. *Beyond the New Right. Markets, Government and the Common Environment*. London and New York: Routledge, 1993 p. 52.
- ³⁴ Kernohan A. *Liberalism, Equality, and Cultural Oppression* Cambridge: Cambridge University Press, 1998, p. ix.
- ³⁵ Kekes J. *Against Liberalism*, Cornell: Cornell University Press, 1997, p. 120.
- ³⁶ On definitions of freedom see, e.g., Kleinig J. *Paternalism*. Manchester: Manchester University Press, 1983, pp. 19-21.
- ³⁷ Feinberg J. *Rights, Justice, and the Bounds of Liberty*. Princeton: Princeton University Press, 1980, pp. 49 ff; Feinberg J. *Harm to Others*. Oxford: Oxford University Press, 1984, p. 212.
- ³⁸ Mill J.S., *On Liberty* (orig. 1859), reprinted in Wollheim R. (ed.), *Three Essays*. Oxford: Oxford University Press, 1975, pp. 22 ff.

-
- ³⁹ Dworkin G. 'Moral Autonomy' In Engelhardt Jr. HT, Callahan D. (eds.), *Morals, Science and Sociality Vol III: The Foundations of Ethics and Its Relationship to Science*. New York: The Hastings Center, 1978, pp. 164-166.
- ⁴⁰ Häyry (Gylling) H, *Individual Liberty and Medical Control*. Ashgate, 1998, p. 64.
- ⁴¹ Beauchamp TL, Childress JF. *Principles of Biomedical Ethics (5th ed)*. Oxford: Oxford University Press, 2001, pp. 63-64.
- ⁴² Dickenson D. *Moral Luck in Medical Ethics and Practical Politics*. Aldershot: Avebury, 1991.
- ⁴³ Herman B. *The Practice of Moral Judgment*. Cambridge, MA: Harvard University Press, 1993. p. 75
- ⁴⁴ Buchanan D. *An Ethic for Health Promotion. Rethinking the Sources of Human Well-Being*. New York/Oxford: Oxford University Press, 2000.
- ⁴⁵ Glanz K, Lewis FM, Rimer BK (eds). *Health behavior and health education : theory, research, and practice*. San Francisco : Jossey-Bass, 1997.
- ⁴⁶ Dewey J. *The Public and Its Problems*. Athens Ohio: Swallow Press, 1991, p. 15-16.
- ⁴⁷ *Kant's Political Writings*, trans. H.B. Nisbet, ed. by H. Reiss (Cambridge: Cambridge University Press, 2nd enlarged edition, 1991) for "An Answer to the Question: What is Enlightenment?", pp. 54-60
- ⁴⁸ Reiss HS. *Kant – Political Writings*. Cambridge Texts in the History of Political Thought. Cambridge: Cambridge University Press, 2004. p. 257.
- ⁴⁹ Vos R. *Public Use of Reason in Kant's Philosophy: deliberative or reflective?* Proceedings of the Kantian Society, 2007, forthcoming.
- ⁵⁰ Benshop R, Horstman K, Vos R. Voice beyond choice – hesitant voice in public debates about genetics in health care. *Health Care Analysis* 2003; 11(2):141-150.
- ⁵¹ Ricoeur P. *The Just*. Chicago: the University of Chicago Press, 2000 (particularly chapter 'The Concept of Responsibility'), pp11-35.
- ⁵² This part is derived from the intriguing analysis on the history and development of the notion of responsibility by Ricoeur P. *The Just*. Chicago: the University of Chicago Press, 2000 (particularly chapter 'The Concept of Responsibility'), pp11-35.
- ⁵³ This part is derived from the illuminating and painstaking analysis between choosing and willing from Dan-Cohen M. *Harmful Thoughts – Essays on Law, Self, and Morality*. Princeton and Oxford: Princeton University Press, 2002 (particularly chapter 4 'Conceptions of Choice and Conceptions of Autonomy'), pp. 125-149.
- ⁵⁴ This part is derived from the fascinating analysis on the 'plasticity' of individual and social responsibility from Dan-Cohen M. *Harmful Thoughts – Essays on Law, Self, and Morality*. Princeton and Oxford: Princeton University Press, 2002 (particularly chapter 7 'Responsibility and The Boundaries of The Self'), pp. 199-245.
- ⁵⁵ Hirschman AO. *Essays in Trespassing: Economics to Politics and Beyond*, Cambridge: Cambridge University Press, 1981, p. 220. Cf. also Hirschman AO. *Exit, Voice and Loyalty*. Harvard University Press, 1970.
- ⁵⁶ Benshop R, Horstman K, Vos R. Voice beyond choice – hesitant voice in public debates about genetics in health care. *Health Care Analysis*, 2003; 11(2):141-50.

⁵⁷ This point as well as how this affects the scope of responsibility I owe to the fascinating analysis on the ‘plasticity’ of individual and social responsibility from Dan-Cohen M. *Harmful Thoughts – Essays on Law, Self, and Morality*. Princeton and Oxford: Princeton University Press, 2002 (particularly chapter 7 ‘Responsibility and The Boundaries of The Self’), pp. 199-245.

⁵⁸ Rhodes R. ‘Justice in medicine and public health’. *Cambridge Quarterly of Healthcare Ethics* 2005 14:13-26.

⁵⁹ Mackenbach JP. Odol, Autobahne and a non-smoking Führer: Reflections on the innocence of public health. *International Journal of Epidemiology* 2005; 34(3): 537-539.

⁶⁰ Häyry M. Utilitarianism and bioethics. In: Ashcroft R, Draper H, McMillan J. (eds.), *Principles of Health Care Ethics* [2nd edition]. Chichester: Wiley, 2007.

⁶¹ Bentham J. (1789) *An Introduction to the Principles of Morals and Legislation*. Methuen: London and New York, 1970.

⁶² Husted J. *Insurance, Genetics and Solidarity*. In *Genetics and Insurance*. T. McGleenan U. Wiesing, F. Ewald F, eds. Oxford, UK: BIOS Scientific Publishers Limited.

⁶³ Sandel MJ. *Liberalism and the Limits of Justice*. New York: Cambridge University Press, 1983

⁶⁴ MacIntyre A. *After Virtue*. Notre Dame: University of Notre Dame Press, 1981.

⁶⁵ Parfitt D. *Reasons and Persons*. Oxford: Oxford University Press, 1984.

⁶⁶ Sandel M. The Political Theory of the Procedural Republic. *Revue de Metaphysique et de Morale* 1988; 93: 57-68

⁶⁷ Walzer M. *Spheres of Justice*. Oxford: Blackwell, 1983.

⁶⁸ Taylor C. *Atomism*. In: Avineri S, de-Shalit A. *Communitarianism and Individualism*. Oxford: Oxford University Press, 1992.

⁶⁹ Rousseau J-J. A Discourse on Political Economy”. In: Cole GDH (trans.). *The Social Contract and Discourses*. New York: 1950: 302-3.

⁷⁰ Durkheim E. *The Division of Labour in Society*. In Hall WD (trans.). Basinstoke: Macmillan Press, 1984. p. 288

⁷¹ Durkheim E. La Science positive de la morale en Allemagne. *Revue philosophique* 19878; 24: 33-58, 113-42, 275-84.

⁷² Durkheim E. L’Indiviuualism et les intellectuels [Individualism and the Intellectuals]. *Revue bleue*, 4^e série, 10, 1898: 7-13.

⁷³ Bentham J. *An Introduction to the Principles of Morals and Legislation*. In Burns JH, Hart HLA (eds.) London: Athlone Press, 1970. p. 12

⁷⁴ Shickle D. Privacy versus public right to know. In: Chadwick R (ed.). *Encyclopedia of Applied Ethics*, Volume 3. Academic Press, 1998: 661-669.

⁷⁵ Tommaso D’Aquino. *Summa Teologica*, pt. I, q. 29, a. 3-5.

⁷⁶ Galeazzi G. (1998). *Personalismo*. Editrice Bibliografica, Milano, p. 57-63.

⁷⁷ Sgreccia E., Torlone G. (2006). *Persona humana y personalismo*. In: Diccionario de Bioética. Editorial Monte Carmelo, Burgos (Spain), in press.

⁷⁸ Fornero G. (2005). *Bioetica cattolica e bioetica laica*. Mondadori, Milano, p. 28.

⁷⁹ Fornero G. (2005). *Cit.*

- ⁸⁰ Sgreccia E. (1999). *Manuale di Bioetica. Vol. I. Fondamenti di etica biomedica*. Vita e Pensiero, Milano.
- ⁸¹ Carrasco de Paula I. (2004). Il concetto di persona e la sua rilevanza assiologica: i principi della bioetica personalista. *Medicina e Morale*, 54 (2): 265-272.
- ⁸² Petrini C. Alcune considerazioni sui principi della bioetica applicati alla sanità pubblica. Parte prima: aspetti generali. *Biologi italiani*, 2005; 35 (10): 41-48.
- ⁸³ Petrini C. Alcune considerazioni sui principi della bioetica applicati alla sanità pubblica. Parte seconda: principilismo, personalismo e sanità pubblica. *Biologi italiani*, 2005; 35 (11): 13-19.
- ⁸⁴ Lipovetsky G. (1992). *Le crépuscule du devoir. L'éthique indolore des nouveaux temps démocratiques*. Gallimard, Paris; Jeffrey D. (1998). *Éthique et postmodernité*. In: Boisvert Y. (ed.) *Postmodernité et sciences humaines: une notion pour comprendre notre temps*. Éditions Liber, Montréal.
- ⁸⁵ Beauchamp D. E. (2003). *Public Health. III. Philosophy*. In: Post S. G. (ed.) *Encyclopedia of Bioethics*, Macmillan Reference USA, p. 2211.
- ⁸⁶ Priester R. (1992). A values framework for health system reform. *Health Affairs*, 11 (2): 84-107.
- ⁸⁷ Bard J. (2005). Standing together: how bioethics and public health can join forces to provide equitable health care. *The American Journal of Bioethics*, 5(5):W20.
- ⁸⁸ Last J. M. (1987). *Public health and human ecology*. Appleton & Lange, East Norwalk, p. 351-370.
- ⁸⁹ Doucet H. (2000). *Pénaliser le citoyen irresponsable: une attitude sociale responsable?* In: *Les enjeux éthiques en santé publique. Actes du colloque tenu le 20 et 21 mai 1999, Montréal*. Association pour la Santé Publique du Québec (AS PQ), Montréal, p. 57-77.
- ⁹⁰ Renard C. (2001). Vers une éthique de la co-responsabilité. De l'éducation à la santé à la promotion de la santé. *Les Politiques Sociales*, 1-2 : 107-112.
- ⁹¹ Lamoreux H. (1996). *Le citoyen responsable: l'éthique de l'engagement social*. VLB, Québec, p. 77.
- ⁹² Ibidem.
- ⁹³ Buttiglione R., Pasquini M. (2002). *The challenge of government in constructing of health care policy*. In: Taboada P., Cuddeback K. F., Donohue-White P. *Person society and value. Towards a personalist concept of health*. Kluwer Academic Publishers, Dordrecht, p. 229-239.
- ⁹⁴ Beauchamp D. E., Steinbock B. (1999). *Introduction. Ethical theory and public health*. In: Beauchamp D., Steinbock B. (eds.) *New ethics for the public's health*. Oxford University Press, New York, p. 3-23.
- ⁹⁵ Fizzoti E. (2005). La fondamentale dimensione comunitaria dell'esistenza. La filosofia personalistica in aiuto della psicologia. *L'Osservatore Romano*, 145 (175): 3.
- ⁹⁶ Pellegrino E. D., Thomasma D. C. (2004). *The good of patients and the good of society: striking a moral balance*. In: Boylan M. (ed.) *Public health policy and ethics*. Kluwer Academic Publishers, Dordrecht, p. 17-37.
- ⁹⁷ Sgreccia E. (1999). *Cit.*, p. 167.
- ⁹⁸ Kerr E. Luxembourg Directorate of Health, Luxembourg Ministry of Health, Luxembourg Inspectorate of Social Security & The Union of Sickness Funds,

Luxembourg. *Health Care Systems in Transition: Luxembourg*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 1999

⁹⁹ Duprat DP. France. In Hurrelmann K, Laaser U. eds. *International Handbook of Public Health*. Westport, Connecticut & London: Greenwood Press, 1996

¹⁰⁰ McCarthy M, Rees S. *Health Systems and Public Health Medicine in the European Community*. London: Faculty of Public Health Medicine, Royal College of Physicians, 1992.

¹⁰¹ Rico A, Sabes R, Wisbaum W. *Health Care Systems in Transition: Spain*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2000

¹⁰² Bentes M, Dias CM, Sakellarides C, et al. *Health Care Systems in Transition: Portugal*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2004

¹⁰³ Tragakes E, Polyzos, N. *Health Care Systems in Transition: Greece*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 1996

¹⁰⁴ Faculty of Public Health. Eligibility for Higher Specialist Training in Public Health. [Accessed 6 September 2006] Available from: http://www.fph.org.uk/training/higher_specialist_training_programme/eligibility.asp

¹⁰⁵ Robinson R, Dixon A. *Health Care Systems in Transition: UK*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 1999

¹⁰⁶ Busse R, Riesberg A. *Health Care Systems in Transition: Germany*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2004

¹⁰⁷ Hofmarcher MM, Rack H. *Health Care Systems in Transition: Austria*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2001

¹⁰⁸ Karski JB, Koronkiewicz A, Healy J. *Health Care Systems in Transition: Poland*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 1999

¹⁰⁹ Kerr E, Siebrand V, Defever M, et al. *Health Care Systems in Transition: Belgium*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2000

¹¹⁰ Alvarez-Dardet, C. Spain. In Marinker M. Ed. *Health Targets in Europe: Polity, Progress and Promise*. London: BMJ Books, 2002

¹¹¹ den Exter A, Hermans H, Dosljak M, et al. *Health Care Systems in Transition: Netherlands*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Office, 2004

¹¹² Hjortsberg C, Ghatnekar O. *Health Care Systems in Transition: Sweden*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2001

¹¹³ Järvelin J. *Health Care Systems in Transition: Finland*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2002

¹¹⁴ Vallgård S, Krasnik A, Vrangbæk K. *Health Care Systems in Transition: Denmark*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2001

¹¹⁵ von Troschke J, Hoffmann-Markwald A, Stöbel U. Germany. In Hurrelmann K & Laaser U, Eds. *International Handbook of Public Health*. Westport, Connecticut & London: Greenwood Press, 1996

¹¹⁶ Stein H. Germany. In Marinker M, Ed. *Health Targets in Europe: Polity, Progress and Promise*. London: BMJ Books, 2002

¹¹⁷ Sandier S, Paris V, Polton D. *Health Care Systems in Transition: France*. Copenhagen: European Observatory on Health Care Systems, WHO Regional Offices, 2004

¹¹⁸ Guillén AM, Álvarez S. Globalization and the Southern Welfare States. In Sykes R, Palier B, Prior PM, Eds. *Globalization and European Welfare States: Challenges and Change*. Palgrave: Basingstoke, UK, 2001

¹¹⁹ European Monitoring Centre for Drugs and Drug Addiction [EMCDDA]. *The State of the Drugs Problem in the European Union and Norway: Annual Report 2003*, Luxembourg: Office for Official Publications of the European Communities, 2003.

¹²⁰ European Legal Database on Drugs [ELDD] (2003) *Country Profiles* Available from: http://eldd.emcdda.eu.int/databases/eldd_country_profiles.cfm

¹²¹ European Monitoring Centre for Drugs and Drug Addiction [EMCDDA]. *The State of the Drugs Problem in the European Union and Norway: Annual Report 2003*. Luxembourg: Office for Official Publications of the European Communities, 2003.

¹²² World Bank. Tobacco control at a glance, Washington DC, 2003, [Accessed 20 September 2006] Available from: www.worldbank.org/tobacco2

¹²³ Council Directive 95/59/EC of 27 November 1995 on taxes other than turnover taxes which affect the consumption of manufactured tobacco, Council Directive 92/79/EEC of 19 October 1992 on the approximation of taxes on cigarettes and Council Directive 92/80/EEC of 19 October 1992 on the approximation of taxes on manufactured tobacco other than cigarettes.

¹²⁴ Factsheet no:20 Tobacco policy in the European Union, Action on Smoking and Health. May, 2006. [Accessed 20 September 2006] Available from: <http://www.ash.org.uk/html/factsheets/html/fact20.html>

¹²⁵ EU Commissioner warns Germany over tobacco ads, Eubusiness 12 April, 2006 [Accessed 20 September 2006] Available from: <http://www.eubusiness.com/Health/060412093650.1grk3rca>

¹²⁶ Council Directive 89/654/EEC of 30 November 1989 concerning the minimum safety and health requirements for the workplace

¹²⁷ Council Directive 92/85/EEC of 19 October 1992 concerning the implementation of measures to encourage improvements in the safety and health of pregnant workers, women workers who have recently given birth and women who are breastfeeding.

¹²⁸ Forest Smoking in public places December 2006 [Accessed 20 September 2006] Available from <http://www.forestonline.org/output/page17.asp>

¹²⁹ Council Directive on the regulation of tobacco products.

¹³⁰ Council Directive on the regulation of tobacco products.

¹³¹ The New EU Chemicals Legislation – REACH [Accessed 20 September 2006] Available from: http://ec.europa.eu/enterprise/reach/index_en.htm,

-
- ¹³² Press release of the EU Council of Agriculture Ministers. 8401/04 (Presses 112) 21-22 April 2004 [Accessed 20 September 2006] Available from: <http://www.ensp.org/files/80010.pdf>
- ¹³³ Dangerous Dogs Act 1991 (c. 65), The Stationery Office Limited ISBN 0105465917 [Accessed 20 September 2006] available from: http://www.opsi.gov.uk/ACTS/acts1991/Ukpga_19910065_en_1.htm
- ¹³⁴ Dangerous Dogs (Amendment) Act 1997 Stationery Office Limited ISBN 0 10 545397 8. [Accessed 20 September] available from: <http://www.opsi.gov.uk/ACTS/acts1997/1997053.htm>
- ¹³⁵ Firearms (Amendment) Act 1988 (c. 45), The Stationery Office Limited ISBN 0105445886. [Accessed 20 September] available from: http://www.opsi.gov.uk/ACTS/acts1988/Ukpga_19880045_en_1.htm
- ¹³⁶ Gun Control Education Pack [Accessed 20 September] available from <http://www.gun-control-network.org/EP01.htm>
- ¹³⁷ Glaser BG. *Theoretical Sensitivity. Advances in the methodology of Grounded Theory*. Mill Valley, CA: Sociology Press 1978
- ¹³⁸ Kitzinger J. The methodology of focus groups: the importance of interaction between research participants *Sociology of Health* 1994; 16 103-21.
- ¹³⁹ Warr DJ. "It was fun...but we don't usually talk about these things": Analyzing Sociable Interaction in focus groups *Qualitative Inquiry* 2005; 11: 200-225
- ¹⁴⁰ Hildebrandt E. Focus groups and vulnerable populations. Insight into client strengths and needs in complex community health care environments. *Nurs Health Care Perspect*. 1999;20(5):256-9.
- ¹⁴¹ Shafritz LB, Roberts A. The value of focus-group research in targeting communication strategies: an immunisation case study. *Health Transit Rev*. 1994; 4(1):81-5.
- ¹⁴² Bender DE, Ewbank D. The focus group as a tool for health research: issues in design and analysis. *Health Transit Rev*. 1994;4(1):63-80.
- ¹⁴³ UNICEF [Accessed 2006 April 25]. Available from: <http://www.unicef.org/polls/cee/home/index.html> [Accessed 2006 April 25]
- ¹⁴⁴ Sariola H, Uutela A. The prevalence and context of family violence against children in Finland. *Child Abuse Negl* 1992; 16(6):823-32
- ¹⁴⁵ Murphy-Cowan T, Stringer M. Physical punishment and the parenting cycle: a survey of Northern Irish parents. *Journal of Community & Applied Social Psychology* 1999; 9 (1): 61-71
- ¹⁴⁶ Thompson AE, Pearce JB. Attitudes towards and the practice of discipline amongst parents of pre-school children in Nottingham Disciplining pre-school children. *Children & Society* 2001;15 (4):231-236
- ¹⁴⁷ End Corporal Punishment. [Accessed 2006 April 25]. Available from: <http://www.endcorporalpunishment.org/pages/frame.html>
- ¹⁴⁸ Larzelere RE. Child Outcomes of Nonabusive and Customary Physical Punishment by Parents: An Updated Literature Review. *Clin Child Fam Psychol Rev* 2000;3(4):199-221

-
- ¹⁴⁹ Hain RD. Child discipline. Occasional smacking does no harm. *BMJ* 2000;320(7248):1539
- ¹⁵⁰ Waterston T. Giving guidance on child discipline - Physical punishment works no better than other methods and has adverse effects. *BMJ* 2000;320(7230): 261–262.
- ¹⁵¹ Phillips B, Alderson P. Beyond ‘anti-smacking’: Challenging violence and coercion in parent-child relations. *The International Journal of Children’s Rights* 2003;115:175–197,.
- ¹⁵² Family Youth Organisation. British Market Research Bureau. Survey on smacking, 2004. [Accessed 2006 April 25] Available from <http://www.famyouth.org.uk>
- ¹⁵³ Dhooper SS, Royse DD, Wolfe LC. A statewide study of the public attitudes toward child abuse. *Child Abuse Negl.* 1991;15(1-2):37-44
- ¹⁵⁴ Socolar RR, Stein RE. Spanking infants and toddlers: maternal belief and practice. *Pediatrics* 1995;95(1):105-11
- ¹⁵⁵ Department of Health. ONS Omnibus Survey 1998, Protecting Children, Supporting Parents. [Accessed 2006 April 25] Available from: <http://www.dh.gov.uk/assetRoot/04/05/48/48/04054848.pdf>
- ¹⁵⁶ The Scottish Executive Justice Department. The Physical Punishment of Children in Scotland: A Consultation. [Accessed 2006 April 25] Available from: <http://www.scotland.gov.uk/library2/doc11/ppcs-00.asp>
- ¹⁵⁷ Children are unbeatable. MORI, Attitudes to hitting family members, Research study conducted for the Children are Unbeatable Alliance. 2004. [Accessed 2006 April 20] Available from <http://www.childrenareunbeatable.org.uk/>
- ¹⁵⁸ Article 19, U.N. Convention on the Rights of the Child Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989
- ¹⁵⁹ Larzelere RE, Johnson B. Evaluations of the effects of Sweden's spanking ban on physical child abuse rates: a literature review. *Psychol Rep.* 1999;85(2):381-92.
- ¹⁶⁰ Sanden A. Spanking and other forms of physical punishment: a study of adults' and middle school students' opinions, experience, and knowledge. Cited in Larzelere RE. Child discipline - Weak evidence for a smacking ban. *BMJ* 2000; 320(7248):1538
- ¹⁶¹ Durrant JE. Evaluating the success of Sweden's corporal punishment ban. *Child Abuse Negl* 1999;23(5):435-48.
- ¹⁶² European Commission Memo: *Halving the number of road accident victims in the EU by 2010: A shared responsibility. European road safety action programme.* [Accessed 5 December 2006] Available from: http://ec.europa.eu/transport/road/library/rsap/memo_rsap_en.pdf [Accessed 5 December 2006]
- ¹⁶³ Commission of the European Communities. (2001) *White Paper: European Transport Policy for 2010: Time to Decide*. Brussels: Commission of the European Communities. [Accessed 5 December 2006] Available from: http://portal.etsi.org/publicinterest/Documents/policy%20documents/Transport/white_paper.pdf

-
- ¹⁶⁴ European Transport Safety Council. (2006). *Enforcement Monitor 08: ETSC's Newsletter on Traffic Law in the EU*. Brussels: ETSC. [Accessed 5 December 2006] Available from: <http://www.etsc.be/documents/Enforcement%20Monitor%2008.pdf>
- ¹⁶⁵ European Commission Recommendation. (2004). *Commission Recommendation of 6 April 2004 on Enforcement in the Field of Road Safety*. [Accessed 5 December 2006] Available from: http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexplus!prod!CELEXnumdoc&lg=en&numdoc=32004H0345
- ¹⁶⁶ ICF Consulting. (2003) *Cost-Benefit Analysis of Road Safety Improvements: Final Report*. London. Imperial College Centre for Transport Studies. [Accessed 5 December 2006] Available from: http://ec.europa.eu/transport/road/library/icf_final_report.pdf
- ¹⁶⁷ Council Directive 91/671/EEC of 16 December 1991 on the approximation of the laws of the Member States relating to compulsory use of safety belts in vehicles of less than 3,5 tonnes. Brussels: Council of the European Communities. [Accessed 5 December 2006] Available from: http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexplus!prod!DocNumber&type_doc=Directive&an_doc=1991&nu_doc=671&lg=en
- ¹⁶⁸ Directive 2003/20/EC of the European Parliament and of the Council of 8 April 2003 amending Council Directive 91/671/EEC on the approximation of the laws of the Member States relating to compulsory use of safety belts in vehicles of less than 3,5 tonnes. Official Journal of the European Union L 115/63 - L 115/67 [Accessed 5 December 2006] Available from: http://europa.eu.int/eur-lex/pri/en/oj/dat/2003/l_115/l_11520030509en00630067.pdf
- ¹⁶⁹ Chaudhary NK, Northrup VK. (2004). Predictive Models of Safety Belt Use: A regression Analysis. *Traffic Injury Prevention* (5) 137-143.
- ¹⁷⁰ SARTRE consortium. 2004. European Drivers and Road Risk: Arcueil: Institut National de Recherche sur les Transports et leur Sécurité INRETS. [Accessed 5 December 2006] Available from: <http://sartre.inrets.fr/english/pub-en.htm>
- ¹⁷¹ Harrison WA, Senserrick T, Tingvall C. 2000 *Development and Trial of a Method to Investigate the Acceptability of Seat Belt Reminder Systems*. Report 170. Victoria: Monash University Accident Research Centre. [Accessed 5 December 2006] Available from: <http://www.monash.edu.au/muarc/reports/muarc170.pdf>
- ¹⁷² European Transport Safety Council (ETSC) 2006 *Fact Sheet: Promoting Seat Belt Use*. Brussels: ETSC. [Accessed 5 December 2006] Available from: http://www.etsc.be/documents/Fact_Sheet_Seat_Belt_Use_2006.pdf
- ¹⁷³ European Transport Safety Council (ETSC) 2006. *SEC Belt Monitor 6*. Brussels: ETSC. [Accessed 5 December 2006] Available from: http://www.etsc.be/documents/SEC_Belt_Monitor_6.pdf
- ¹⁷⁴ European Transport Safety Council (ETSC) 2006. *Seat Belt Reminders: Implementing advanced safety technology in Europe's cars*. Belgium: ETSC. [Accessed 5 December 2006] Available from: http://www.etsc.be/documents/ETSC_Seat_belt_reminder_oct_06.pdf

-
- ¹⁷⁵ Bentley JJ, Kurrus R, Beuse N. 2003 *Qualitative Research Regarding Attitudes Towards Four Technologies Aimed at Increasing Safety Belt Use*. Report 2003-01. Bethesda, Md : Equals Three Communications, Inc.
- ¹⁷⁶ European Transport Safety Council (ETSC) 2006 *Traffic Law Enforcement across the EU: An Overview*. Brussels: ETSC. [Accessed 5 December 2006] Available from: http://www.etsc.be/documents/Traffic_Law_Enforcement_in_the_EU_An_Overview_May_2006_ETSC.pdf
- ¹⁷⁷ Chaudhary NK, Soloman, MG, Cosgrove LA. 2004 Relationship Between the Perceived Risk of Being Ticketed and Self-Reported Seat Belt Use. *Journal of Safety Research* (35) 383-390.
- ¹⁷⁸ General Population Surveys of drug use; EMCDDA statistical bulletin 2005 [Accessed 09 August 2006] Available from: <http://stats05.emcdda.europa.eu/en/page004-en.html>
- ¹⁷⁹ Monshouwer K, Smit F, De Graaf R, Van Os J, Vollebergh W. First cannabis use: does onset shift to younger ages? Findings from 1988 to 2003 from the Dutch National School Survey on Substance Use. *Addiction* 2005; 100: 963-970
- ¹⁸⁰ Ter Bogt T, Schmid H, Gabhainn SH, Fotiou A, Vollebergh W. Economic and cultural correlates of cannabis use among mid-adolescents in 31 countries. *Addiction* 2005; 101: 241-251
- ¹⁸¹ Gatto C, St. Pierre A. European Drug Policy: Analysis and Case Studies NORML Foundation 1999 [Accessed 09 August 2006] Available from: http://www.norml.org/index.cfm?Group_ID=4415
- ¹⁸² Willner PA. View through the gateway: expectancies as a possible pathway from alcohol to cannabis. *Addiction* 2001; 96:691-703
- ¹⁸³ Fergusson DM, Horwood LJ. Does cannabis use encourage other forms of illicit drug use? *Addiction* 2000; 95: 4, 505-520
- ¹⁸⁴ Legalise Cannabis Alliance. Available from: <http://www.lca-uk.org/> (accessed 09 August 2006)
- ¹⁸⁵ The National Organisation for the Reform of Marijuana Laws. [Accessed 09 August 2006] Available from: <http://www.norml.org/>
- ¹⁸⁶ Media Awareness Project. [Accessed 09 August 2006] Available from: <http://www.mapinc.org/>
- ¹⁸⁷ Fetherston J, Lenton S. Community attitudes towards cannabis law and the proposed Cannabis Infringement Notice scheme in Western Australia. *Drug & Alcohol Review* 2005; 24:301-309
- ¹⁸⁸ Harrison LD, Backenheimer M, Inciardi JA. Cannabis use in the United States: Implications for policy. In: Cohen P & Sas A, editors. *Cannabisbeleid in Duitsland, Frankrijk en de Verenigde Staten*. Amsterdam, Centrum voor Drugsonderzoek, Universiteit van Amsterdam. 1996 pp. 179-276.
- ¹⁸⁹ Skretting A. Attitude of the Norwegian population to drug policy and drug-offences. *Addiction* 1993; 88:125-31
- ¹⁹⁰ Flash Eurobarometer. Young people and drugs. Fieldwork: April-May 2004. [Accessed 09 August 2006] Available from: http://ec.europa.eu/public_opinion/flash/fl158_en.pdf

-
- ¹⁹¹ United Nations Office on Drugs and Crime , 2003 Research Section of the United Nations International Drug Control Programme
- ¹⁹² European Monitoring Centre for Drugs and Drug Addiction [Accessed 09 August 2006] Available from: <http://www.emcdda.europa.eu/>
- ¹⁹³ Amos A, Wiltshire S, Bostock Y, Haw S., McNeill A. 'You can't go without a fag...you need it for your hash' –a qualitative exploration of smoking, cannabis and young people' *Addiction* 2004; 99:77-81
- ¹⁹⁴ New survey of public attitude on cannabis. IMC research [Accessed 09 August 2006] Available from: <http://www.icmresearch.co.uk/reviews/2001/guardian-poll-july-2001>.
- ¹⁹⁵ Parker P, Williams L, Aldridge J. The Normalization of 'Sensible' Recreational Drug Use: Further Evidence from the North West England Longitudinal Study *Sociology* 2002; 36;4:941-964
- ¹⁹⁶ European Monitoring Centre for Drugs and Drug Addiction] [Accessed 09 August 2006] Available from: <http://www.emcdda.europa.eu/>
- ¹⁹⁷ New survey of public attitude on cannabis. IMC research [Accessed 09 August 2006] Available from: <http://www.icmresearch.co.uk/reviews/2001/guardian-poll-july-2001.htm>
- ¹⁹⁸ New survey of public attitude on cannabis. IMC research [Accessed 09 August 2006] Available from: <http://www.icmresearch.co.uk/reviews/2001/guardian-poll-july-2001.htm>
- ¹⁹⁹ New survey of public attitude on cannabis. IMC research European Drug Policy: 2002 Legislative Update [Accessed 09 August 2006] Available from: http://www.norml.org/index.cfm?Group_ID=5446
- ²⁰⁰ New survey of public attitude on cannabis. IMC research [Accessed 09 August 2006] Available from: <http://www.icmresearch.co.uk/reviews/2001/guardian-poll-july-2001.htm>
- ²⁰¹ Chapman S, Haddad S, Sindhusake D. Do work-place smoking bans cause smokers to smoke "harder"? Results from a naturalistic observational study. *Addiction* 1997; 92: 607-610.
- ²⁰² McDonagh M, Whiting P, Bradley M, *et al.* *A Systematic Review of Public Water Fluoridation*. York: University of York, 2000. [Accessed 29 March 2006] Available from: <http://www.york.ac.uk/inst/crd/pdf/fluorid.pdf>
- ²⁰³ Musto RJ. Fluoridation: Why is it not more widely adopted? *CMAJ* 1987;137:707-708.
- ²⁰⁴ Horowitz HS. The effectiveness of community water fluoridation in the United States. *J Public Health Dent* 1996;56(5):253-8.
- ²⁰⁵ O'Mullane DM, Whelton HP, Costelloe P, Clarke D, McDermott S. Water fluoridation in Ireland. *Community Dent Health* 1996;13(2):38-41.
- ²⁰⁶ Sutton PRN. Are Most Fluoridation Promoters Neurotics? *Med Hypotheses* 1992;39:199-200.
- ²⁰⁷ Groves B. *Fluoride: Drinking Ourselves to Death?* Dublin: Gill & Macmillan, 2001

-
- ²⁰⁸ Bryson C. *The Fluoride deception*. New York: Seven Stories Press, 2004.
- ²⁰⁹ Centre for Reviews and Dissemination. What the 'York Review' on the fluoridation of drinking water really found: A statement from the Centre for Reviews and Dissemination (CRD). Released 28 October 2003. [Accessed 17 August 2006] Available from: <http://www.york.ac.uk/inst/crd/fluoridnew.htm>
- ²¹⁰ Hastings GB, Hughes K, Lawther S, Lowry RJ. The role of the public in water fluoridation: public health champions or anti-fluoridation freedom fighters? *Br Dent J* 1998;184(1):39-41.
- ²¹¹ Dixon S, Shackley P. Estimating the Benefits of Community Water Fluoridation Using the Willingness-to-Pay Technique: Results of a Pilot Study. *Community Dent and Oral Epidemiol* 1999;27:124-129.
- ²¹² Lowry RJ, Thompson B, Lennon MA. How Much do the General Public Want to be involved in Decisions on Implementing Water Fluoridation? *Br Dent J* 2000;188:500-502.
- ²¹³ Kay EJ, Blinkhorn AS. A Study of Mother's Attitudes Towards the Prevention of Caries with Particular Reference to Fluoridation and Vaccination. *Community Dent Health* 1989;6(4):357-363.
- ²¹⁴ Helöe LA, Birkeland JM. The Public Opinion in Norway on Water Fluoridation. *Community Dent and Oral Epidemiol* 1974;2:95-97.
- ²¹⁵ Schwartz E, Hansen ER. Public Attitudes Concerning Fluoridation in Denmark. *Community Dent and Oral Epidemiol*. 1976;4:182-185.
- ²¹⁶ Rise J, Kraft P. Opinion about Water Fluoridation in Norwegian Adults. *Community Dent Health* 1983;3: 313-320.
- ²¹⁷ Department of Health. *Communicating about Risks to Public Health: Pointers to Good Practice*. London: The Stationery Office, 1998.
- ²¹⁸ Centers for Disease Control. Knowledge and Purpose of Community Water Fluoridation- United States, 1990. *MMWR Morb Mortal Wkly Rep* 1992;41(49):919, 925-927.
- ²¹⁹ Chikte UME, Brand AA. Attitudes to Water Fluoridation in South Africa 1998: Part I. Analysis by age, sex, population and province. *SADJ* 1999;54:537-543.
- ²²⁰ 23. Chikte UME, Brand AA, Louw AJ, Sarvan I. Attitudes to Water Fluoridation in South Africa 1998: Part II. Influence of educational and occupational levels. *SADJ* 2000; 5(1):23-27.
- ²²¹ Isman R. Public Views on Fluoridation and Other Preventive Dental Practices. *Community Dent and Oral Epidemiol* 1983;1: 217-223.
- ²²² Chikte UME, Brand AA. Attitudes to Water Fluoridation in South Africa 1998: Part III. An analysis of pro- and anti-fluoridation attitudes in South Africa. *SADJ* 2000;55:(2):70-76.
- ²²³ Lowry RJ. What the papers say: How does the United Kingdom press treat water fluoridation press threat water fluoridation and does it matter? *Br Dent J* 2000;189(1):14-18.
- ²²⁴ Riordan PJ. Perceptions of dental fluorosis. *J Dent Res* 1993;72(9):1268-1274.

-
- ²²⁵ Alkhatib MN, Holt R, Bedi R. Aesthetically objectionable fluorosis in the United Kingdom. *Br Dent J* 2004;197(6):325-328.
- ²²⁶ Hastings H. Comment on “water fluoridation – the public’s role in the decision-making process”. *Br Dent J* 2000;188(9):496.
- ²²⁷ Hastreiter RJ. Fluoridation conflict: a history and conceptual synthesis. *J Am Dent Assoc* 1983;106:486-490.
- ²²⁸ Holloway PJ. Public attitudes to fluoridation. *R Soc Health J* 1977; 97(2): 58-9.
- ²²⁹ Commission of the European Communities. *Communication from the Commission on the precautionary principle*. Com(2000) 1. Brussels: Commission of the European Communities, 2000
- ²³⁰ Petersen PK, Bourgeois D, Ogawa H, Estupinan-Day S, Ndiaye C. The global burden of oral diseases and risks to oral health. *Bull of the World Health Organ* 2005; 83.
- ²³¹ Heininger U. The success of immunization – shovelling its own grave? *Vaccine* 2004;22(15-16):2071-2.
- ²³² Werko L. There is a risk of reduced reliance of the public on vaccination programs. A new wave of infections can be the consequence. *Lakartidningen* 2002;99(49):4960-3.
- ²³³ Linde A, Johansen K. Vaccination offers good protection against measles, mumps and rubella. To refuse vaccination would seriously threaten our good immunity status. *Lakartidningen* 2001;98(35):3658-64.
- ²³⁴ World Health Organization. Report of the 14th Meeting of the Interagency Immunization Coordinating Committee (21-22 October 2004). *Vaccine-Preventable Diseases and Immunization*: World Health Organization Regional Office for Europe, 2004: 10.
- ²³⁵ MacIntyre CR, Leask J. Immunization myths and realities: Responding to arguments against immunization. *J Paediatr Child Health* 2003;39:487-491.
- ²³⁶ Wakefield AJ, Murch SH, Anthony A, Linnell J, Casson DM, Malik M, Berelowitz M, Dhillon AP, Thomson MA, Harvey P, Valentine A, Davies SE, Walker-Smith JA. Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet* 1998;351:637-641.
- ²³⁷ BBC News. Journal regrets running MMR study. [Accessed 2004 February 20] Available from: <http://news.bbc.co.uk/1/hi/health/3508167.stm>
- ²³⁸ Horton RA statement by the editors of the Lancet. *The Lancet* 2004;363(9411):820-821.
- ²³⁹ Afzal MA, Minor PD, Begley J, *et al*. Absence of measles-virus genome in inflammatory bowel disease. *The Lancet* 1998;351:646-647
- ²⁴⁰ Iizuka M, Nakagomi O, Chiba M, Ueda S, Masamune O. Absence of measles virus in Crohn's disease. *The Lancet* 1995;345:199;
- ²⁴¹ Davis RL, Kramarz P, Bohlke K, *et al*. Measles-Mumps-Rubella and Other Measles-Containing Vaccines Do Not Increase the Risk for Inflammatory Bowel Disease. *Archives of Pediatric and Adolescent Medicine* 2001;155:354-359.

-
- ²⁴² Mills E, Jadad AR, Ross C, Wilson K. Systematic review of qualitative studies exploring parental beliefs and attitudes toward childhood vaccination identifies common barriers to vaccination. *J Clin Epidemiol*. 2005;58(11):1081-8.
- ²⁴³ Dannetun E, Tegnell A, Hermansson G, Giesecke J. Parents' reported reasons for avoiding MMR vaccination. A telephone survey. *Scand J Prim Health Care* 2005;23(3):149-53.
- ²⁴⁴ Smailbegovic MS, Laing GJ, Bedford H. Why do parents decide against immunization? The effect of health beliefs and health professionals. *Child Care Health Dev*. 2003;29(4):303-11.
- ²⁴⁵ Fredrickson DD, Davis TC, Arnould CL, Kennen EM, Hurniston SG, Cross JT, Bocchini JA Jr. Childhood immunization refusal: provider and parent perceptions. *Fam Med*. 2004;36(6):431-9.
- ²⁴⁶ Heining U. An internet-based survey on parental attitudes towards immunization. *Vaccine* 2006;Jun 5; Epub.
- ²⁴⁷ Hilton S, Petticrew M, Hunt K. 'Combined vaccines are like a sudden onslaught to the body's immune system': parental concerns about vaccine 'overload' and 'immune-vulnerability'. *Vaccine* 2006;24(20):4321-7.
- ²⁴⁸ Taylor JA, Cufley D. The association between parental health beliefs and immunization status among children followed by private pediatricians. *Clin Pediatr (Phila)*. 1996;35(1):18-22.
- ²⁴⁹ Strobino D, Keane V, Holt E, Hughart N, Guyer B. Parental attitudes do not explain underimmunization. *Pediatrics* 1996;98(6 Pt 1):1076-83.
- ²⁵⁰ Hak E, Schonbeck Y, De Melker H, Van Essen GA, Sanders EA. Negative attitude of highly educated parents and health care workers towards future vaccinations in the Dutch childhood vaccination program. *Vaccine* 2005;23(24):3103-7. [Netherlands]
- ²⁵¹ Gust DA, Strine TW, Maurice E, Smith P, Yusuf H, Wilkinson M, *et al*. Underimmunization status among children: effects of vaccine safety concerns on immunization status. *Pediatrics* 2004;114(1):e16-22.
- ²⁵² Gust DA, Kennedy A, Shui I, Smith PJ, Nowak G, Pickering LK. Parent attitudes toward immunizations and health care providers: the role of information. *Am J Prev Med*. 2005;29(2):105-12.
- ²⁵³ Casiday R, Cresswell T, Wilson D, Panter-Brick C. A survey of UK parental attitudes to the MMR vaccine and trust in medical authority. *Vaccine* 2006;24(2):177-184. [UK]
- ²⁵⁴ Benin AL, Wisler-Scher DJ, Colson E, Shapiro ED, Holmboe ES. Qualitative analysis of mothers' decision-making about vaccines for infants: The importance of trust. *Pediatrics* 2006;117(5):1532-1541.
- ²⁵⁵ Zimmerman RK, Schlesselman JJ, Baird AL, Mieczkowski TA. A national survey to understand why physicians defer childhood immunizations. *Arch Pediatr Adolesc Med*. 1997;151(7):657-64.
- ²⁵⁶ Janvrin MP, Baudier F, Rotily M, Moatti JP. Opinions and practices of family physicians regarding measles-mumps-rubella vaccination. *Arch Pediatr*. 1996;3(6):602-7.

-
- ²⁵⁷ Trier H. Doctors' attitudes and MMR-vaccination. *Scand J Prim Health Care* 1991;9(1):29-33.
- ²⁵⁸ Evans M, Stoddart H, Condon L, Freeman E, Grizzell M, Mullen R. Parents' perspectives on the MMR immunisation: a focus group study. *Br J Gen Pract.* 2001;51(472):904-10.
- ²⁵⁹ Haurum J, Johansen M. Attitudes and knowledge among parents who do not want their children to be vaccinated against measles, mumps and rubella (MMR-vaccination). *Ugeskr Laeger.* 1991;153(10):705-9.
- ²⁶⁰ Salmon DA, Moulton LH, Omer SB, DeHart MP, Stokley S, Halsey NA. Factors associated with refusal of childhood vaccines among parents of school-aged children: a case-control study. *Arch Pediatr Adolesc Med.* 2005;159(5):470-6.
- ²⁶¹ Henderson R, Oates K, Macdonald H, Smith WC. General practitioners' concerns about childhood immunisation and suggestions for improving professional support and vaccine uptake. *Commun Dis Public Health.* 2004;7(4):260-6.
- ²⁶² Walker D, Roworth M, Carter H, Jones IG. Measles-mumps-rubella immunization: the role of the general practitioner in achieving a high uptake. *J R Coll Gen Pract.* 1989;39(328):459-60.
- ²⁶³ Peto R, Lopez AD, Boreham J, Thun M, Heath C. *Mortality from Smoking in Developed Countries, 1950-2000: Indirect Estimates from National Statistics.* 1995 Oxford University Press, Oxford.
- ²⁶⁴ Sanford A. Government action to reduce smoking. *Respirology* 2003;8:7-16
- ²⁶⁵ Gilmore A, McKee M. Tobacco control policy: The European dimension *Clinical Med* 2002; 2:335-42
- ²⁶⁶ Chapman S, Haddad S, Sindhusake D. Do work-place smoking bans cause smokers to smoke "harder"? Results from a naturalistic observational study. *Addiction* 1997;92:5: 607-610.
- ²⁶⁷ Council of the European Union (2002) Recommendation on the prevention of smoking and on initiatives to improve tobacco control. Available from: <http://www.ash.org.uk/html/policy/recommendation.html>
- ²⁶⁸ Gallus S, Zuccaro P, Colombo P, Apolone G, Pacifici R, Garattini S, *et al.* Effects of New Smoking Regulations in Italy. *Annals of Oncology* 2005;17: 346-347.
- ²⁶⁹ Martin G, Steyn K, Yach D. Beliefs about smoking and health attitudes toward tobacco control measures. *South African Med J* 1992;82:241-245.
- ²⁷⁰ Pederson L, Bull S, Ashley MJ, Lefcoe NM. A population survey in Ontario regarding restrictive measures on smoking: relationship of smoking status to knowledge, attitudes and predicted behaviour. *Int J Epidemiol* 1987;16:383-391
- ²⁷¹ McAllister I. Public opinion in Australia on restricting smoking in public places. *Tob. Control* 1995;4:30-35.
- ²⁷² Jones S, Love C, Thomson G, Green R, Howden-Chapman P. Second-hand smoke at work: The exposure, perceptions and attitudes of bar and restaurant workers to environmental tobacco smoke. *Aust N Z J Public Health*, 2001;25:90-3.
- ²⁷³ Eurobarometer 43.0:Cross Border Purchases, Smoking Habits and Cancer Prevention, 1995 *European Commission* Available from: <http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=3810>

-
- ²⁷⁴ Special Eurobarometer 183 / Wave 58.2 Smoking and the environment: Actions and attitudes 2003 *European Commission* Available from: http://ec.europa.eu/comm/health/ph_determinants/life_style/Tobacco/Documents/eb582_smoking_env_en.pdf
- ²⁷⁵ Fagerstrom K, Boyle P, Kunze M, Zatonski W. The anti-smoking climate in EU countries and Poland. *Lung Cancer* 2001;32:1:1-5
- ²⁷⁶ Smoking-related Behaviour and Attitudes 2003 National Statistics Department of Health Available from: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=1638>
- ²⁷⁷ Joossens L. Smoking policy in the workplace and other public places. *Lung*. 168 1990;Suppl:437-44
- ²⁷⁸ Brenner H, Born J, Novak P, Wanek V. Smoking Behaviour and Attitude Towards Smoking Regulations and Passive Smoking in the Workplace. *Prev Med* 1997;26:138-143
- ²⁷⁹ Vecchia CL, Garattini S, Colombo P, Scarpino V. Attitudes towards smoking regulation in Italy. *The Lancet* 2001; 358: 9277:245
- ²⁸⁰ Ashley MJ, Bull SB, Pederson LL. Support among smokers and nonsmokers for restrictions on smoking. *Am J Prev Med* 1995;11:283-287
- ²⁸¹ Poland BD, Cohen JE, Ashley MJ, Adlaf E, Ferrence R, Pederson LL, *et al* Heterogeneity among smokers and non-smokers in attitudes and behaviour regarding smoking and smoking restrictions *Tob. Control* 2000;9:364-371 .
- ²⁸² Ashley MJ, Cohen J, Bull S, *et al*. Knowledge about tobacco and attitudes toward tobacco control: how different are smokers and nonsmokers? *Can J Public Health*.2000; 91:376 –380.
- ²⁸³ Semmonds A, Bailey K, *et al* Smoking in hotels: prevalence, and opinions about restrictions. *Aust J Public Health*. 1995;19:1:98-100
- ²⁸⁴ Beck U. Beck-Gernsheim E. *Individualization*. Sage Publications: London; 2001
- ²⁸⁵ Poland BD. The 'considerate' smoker in public space: the micro-politics and political economy of 'doing the right thing' *Health and Place* 2000;6:1:1-14
- ²⁸⁶ Gilmore A, McKee M. Tobacco control policy: The European dimension *Clinical Med* 2002; 2:335-42
- ²⁸⁷ Office for National Statistics, General Household Survey 2004: Smoking and drinking among adults. *National Statistics Omnibus Survey*; 2005: London. Available from: http://www.statistics.gov.uk/downloads/theme_compendia/GHS2004_Smoking%20_and_Drinking_Report.pdf
- ²⁸⁸ Thomson GW, Wilson N. Public attitudes about tobacco smoke in workplaces: the importance of workers' rights in survey questions. *Tob. Control* 2004;12:206-207
- ²⁸⁹ Jones K, Wakefield M, Turnbull DA. Attitudes and experiences of restaurateurs regarding smoking bans in Adelaide, South Australia *Tob. Control* 1999;8:62-6
- ²⁹⁰ Albers AB, Siegel M, Cheng DM, Biener L, Rigotti NA. Relation between local restaurant smoking regulations and attitudes towards the prevalence and social acceptability of smoking: a study of youths and adults who eat out predominantly at restaurants in their town. *Tob. Control* 2004;13:4::347-55

-
- ²⁹¹ Tyler T. *Why people obey the law*. New Haven: Yale University Press, 1990
- ²⁹² Tittle CR. Sanction fear and the maintenance of social order. *Social Forces* 1977; 55: 579-96
- ²⁹³ Repper J, Sayce L, Strong S, Willmot J, Haines M. *Tall Stories from the Back Yard: A Survey of 'Nimby' Opposition to Community Mental Health Facilities Experienced by Key Service Providers in England and Wales*. London: Mind, 1997.
- ²⁹⁴ Cowan S. NIMBY syndrome and public consultation policy: the implications of a discourse analysis of local responses to the establishment of a community mental health facility. *Health and Social Care in the Community* 2003; 11(5): 379-386.
- ²⁹⁵ Angermeyer MC, Beck M, Matschinger H. Determinants of the Public's Preference for Social Distance From People With Schizophrenia. *Canadian Journal of Psychiatry* 2003; 48(10): 663-668.
- ²⁹⁶ Angermeyer MC, Matschinger H. The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatr Scand* 2003; 108: 304-309.
- ²⁹⁷ Gaebel W, Baumann A, Witte AM, Zaeske H. Public attitudes towards people with mental illness in six German cities: Results of a public survey under special consideration of schizophrenia. *Eur Arch Psychiatry Clin Neurosci* 2002; 252: 278-287.
- ²⁹⁸ Stuart H, Arboleda- Flórez J. Community Attitudes Toward People with Schizophrenia. *Canadian Journal of Psychiatry* 2001; 46: 245-252.
- ²⁹⁹ Krueger R. *Focus groups: a practical guide for applied research*. California: SAGE Publications, 1994.
- ³⁰⁰ Angermeyer MC, Matschinger H, Corrigan PW. Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey. *Schizophrenia Research* 2004; 69: 175-182.
- ³⁰¹ Lauber C, Nordt C, Falcato L, Rössler W. Factors Influencing Social Distance Toward People with Mental Illness. *Community Mental Health Journal* 2004; 40(3): 265-274.
- ³⁰² Lauber C, Nordt C, Sartorius N, Falcato L, Rössler W. Public acceptance of restrictions on mentally ill people. *Acta Psychiatrica Scandinavica* 2000; 102 (Suppl. 407): 26-32.
- ³⁰³ Axelrod R. 'An evolutionary approach to norms'. *American Political Science Review*, 1986;80: 1095-1111.
- ³⁰⁴ Kameda T, Takezawa M, Hastie R. Where do social norms come from? The example of communal sharing. *Current Directions in Psychological Science*, 2005;14, 331-334
- ³⁰⁵ Cooter R. Do good Laws make good citizens? An Economic Analysis of Internalised Norms. *Virginia Law Review* 2000; Vol 86, no 8, 1577-1601
- ³⁰⁶ Durkheim E. *Suicide*. The Free Press, New York 1951
- ³⁰⁷ Parsons T. *The social system*. The Free Press, New York 1952

-
- ³⁰⁸ Higgins, ET, Bargh JE. Social cognition and social perception. *Annual Review of Psychology*. 1987;38, 369-425.
- ³⁰⁹ Kallgren C, Reno Cialdini R. A focus Theory of Normative Conduct: When do Norms Do and Do not Affect Behaviour. *Pers Soc Psychol Bull* 2000;26:1002-1012
- ³¹⁰ Horne C. The Internal Enforcement of Norms. *European Sociology Review*, 2003;Vol 19, no 4, 335-343
- ³¹¹ Tyran JR, Feld LP. 2006 Achieving Compliance when Legal Sanctions are Non-deterrent *The Scandinavian Journal of Economics* Volume 108 p135-156
- ³¹² Millar J, Warman A. *Family Obligations in Europe*, London:Family Policy Studies Center. 1996
- ³¹³ Moran NE, Shickle D, Munthe C, Dierickx K, Petrini C, Piribauer F, Czabanowska K, Cowley H, Blancafort S, Petsetakis E. "Are compulsory immunisation and incentives to immunise effective ways to achieve herd immunity in Europe?" in Selgelid M, Battin MP, Smith CB (eds.) *Ethics and Infectious Disease*. Oxford: Blackwell. 2006
- ³¹⁴ Isaacs D, Kilham HA, Marshall HJ. Should routine childhood immunizations be compulsory? *Paediatr Child Health* 2004 Jul;40(7):392-6.
- ³¹⁵ British Medical Association. *Consent, rights and choices in health care for children and young people*. London: British Medical Association 2000.
- ³¹⁶ Diekema DS. *Theor Med Bioeth*. 2004;25(4):243-64. Parental refusals of medical treatment: the harm principle as threshold for state intervention.
- ³¹⁷ Gallus S, Zuccaro P, Colombo P, Apolone G, Pacifici R, Garattini S, La Vecchia C. Effects of new smoking regulations in Italy. *Ann Oncol*. 2006 Feb;17(2):346-7. Epub 2005 Nov 7
- ³¹⁸ Eurobarometer 58.0 European Union citizens and sources of information about health 2003 [Accessed 12 October 2006]Available from: http://ec.europa.eu/health/ph_information/documents/eb_58_en.pdf
- ³¹⁹ Wakefield AJ, Murch SH, Anthony A, Linnell J, Casson DM, Malik M, Berelowitz M, Dhillon AP, Thomson MA, Harvey P, Valentine A, Davies SE, Walker-Smith JA. Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet* 1998; 351: 637-641.
- ³²⁰ Wales C, Harvey M, Warde A. Recuperating from BSE: The shifting UK institutional basis for trust in food. *Appetite* 2006;47: 187-195
- ³²¹ Jacob M, Hellstrom T. Policy understanding of science, public trust and the BSE-CJD crisis. *J Hazard Mater*. 2000 Nov 3;78(1-3):303-17
- ³²² Wakefield AJ, Murch SH, Anthony A, Linnell J, Casson DM, Malik M, Berelowitz M, Dhillon AP, Thomson MA, Harvey P, Valentine A, Davies SE, Walker-Smith JA. Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet* 1998; 351: 637-641.
- ³²³ Butler D. Petition prompts backlash against scientists. *Nature*. 1994 Jan 27;367(6461):304
- ³²⁴ Powell D, Leiss W. *Mad Cows or Crazy Communication? Chapter in mad cows and mother's milk – the perils of poor risk communication* McGill-Queen's University Press 1997

-
- ³²⁵ Wakefield AJ, Murch SH, Anthony A, Linnell J, Casson DM, Malik M, Berelowitz M, Dhillon AP, Thomson MA, Harvey P, Valentine A, Davies SE, Walker-Smith JA. Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet* 1998; 351: 637-641.
- ³²⁶ Halsey NA, MD, Hyman SL, MD, and the Conference Writing Panel. Measles-Mumps-Rubella Vaccine and Autistic Spectrum Disorder: Report From the New Challenges in Childhood Immunizations Conference Convened in Oak Brook, Illinois, June 12-13, 2000. *Pediatrics* Vol. 107 No. 5 May 2001, p. e84
- ³²⁷ Davis RL, Kramarz P, Bohlke K, *et al.* Measles-Mumps-Rubella and Other Measles-Containing Vaccines Do Not Increase the Risk for Inflammatory Bowel Disease. *Archives of Pediatric and Adolescent Medicine* 2001; 155: 354-359
- ³²⁸ Marris C. Public views on GMOs: deconstructing the myths stakeholders in the GMO debate often describe public opinion as irrational. But do they really understand the public? *EMBO Rep.* 2001 July 7; 2(7): 545-548.
- ³²⁹ Lang JT, Hallman WK. Who Does the Public Trust? The Case of Genetically Modified Food in the United States *Risk Analysis* October 2005;25 (5);1241
- ³³⁰ Gambetta D. *Can we Trust Trust?; making and Breaking Cooperative relations*, Gambetta D. (ed.) Basil Blackw Barbara Misztalell, Oxford 1990 (p 213-237))
- ³³¹ Hardin R. Trust decision are made based on the agent's knowledge and experiences. The street Level Epistemology of Trust; *Politics and Society*, 2.1993. pp 505-531
- ³³² Doctors - Public confidence in doctors (Great Britain) November 2006 [Accessed 14 December 2006] Available from: <http://web.bma.org.uk/ap.nsf/content/doctorspublicPU?>
- ³³³ Eurobarometer 2003 [Accessed 20 September 2006] Available from: http://ec.europa.eu/health/ph_information/documents/eb_58_en.pdf
- ³³⁴ IPSOS/MORI on behalf of the Institute for Citizenship/NatWest. State of Citizenship in Britain survey. 1998. [Accessed 10 January 2007] Available from <http://www.mori.com/polls/1998/citizens.shtml>
- ³³⁵ MORI. Young People and Citizenship. 1998. [Accessed 10 January 2007] Available from <http://www.mori.com/2002/c020906.shtml>
- ³³⁶ Organisation for Economic Co-operation and Development. Taxing Wages 2005/2006: Paris: OECD, 2006. [Accessed 23 March 2007] Available at: http://www.oecd.org/document/17/0,2340,en_2649_37427_38148433_1_1_1_37427,00.html
- ³³⁷ European Opinion Research Group. European Commission. Citizenship and sense of belonging. Special Eurobarometer Wave 60.1. European Commission, 2003. [Accessed 10 January 2007] Available from http://ec.europa.eu/public_opinion/archives/ebs/ebs_199.pdf
- ³³⁸ R Jowell and the Central Co-ordinating Team, European Social Survey 2004/2005: Technical Report, London: Centre for Comparative Social Surveys, City University (2005) Available from: <http://www.europeansocialsurvey.org/>
- ³³⁹ Faulks K. *Citizenship in Modern Britain*. Edinburgh, Edinburgh University Press. 1998.

-
- ³⁴⁰ Bellah R, Madsen R, Sullivan W, Swindler A, Tipton S. *Habits of the Heart*. Berkeley. University of California Press 1985.
- ³⁴¹ Knight B, Stokes P. *The Deficit in Civil Society in the Untied Kingdom*. Foundation for Civic Society, Working Paper number 1. 1996.
- ³⁴² Nye J, Zelikow P, King D. *Why Don't People Trust Government*. Cambridge, MA: Harvard University Press. 1997.
- ³⁴³ Whiteley P, Seyed P. *High-Intensity Participation. The Dynamics of Party Activism in Britain*. Ann arbour: University of Michigan Press. 2002.
- ³⁴⁴ Dalton RJ, Wattenburg MP. *Parties without Partisans*. Oxford: Oxford University Press. 2002.
- ³⁴⁵ O'Connor J. *The Fiscal Crisis of the State*. New York: St Martins Press. 1973.
- ³⁴⁶ Charles P, Seyed P, Whiteley P. *Citizenship in Britain: Values, Participation and Democracy*. Cambridge, Cambridge University press. 2004.
- ³⁴⁷ Fraser N, Gordon L. *Contract vs Charity: Why is there No Social Citizenship in the United States?* In Gershon Shafir (ed), *The Citizenship Debates*. Minneapolis: University of Minnesota Press. 1998.
- ³⁴⁸ Axelrod R. *The Evolution of Cooperation*. New York. Basic Books. 1984.
- ³⁴⁹ Axelrod R. *The Complexity of Cooperation*. Princeton, New Jersey. Printceton University Press. 1997.
- ³⁵⁰ Gray J. *Beyond the New Right. Markets, Government and the Common Environment*. London: Routledge, 1993.
- ³⁵¹ See Nozick R. *Anarchy, State, and Utopia* (New York: Basic Books, 1974).
- ³⁵² Kekes J. *Against Liberalism* Cornell: Cornell University Press, 1997, p. 208.
- ³⁵³ *Ibid* p. 209.
- ³⁵⁴ Häyry H. (Gylling, H.), *The Limits of Medical Paternalism*, London: Routledge, 1991.
- ³⁵⁵ Kekes J. *Against Liberalism* Cornell: Cornell University Press, 1997, p. 120.
- ³⁵⁶ Kekes J. *A Case for Conservatism* Cornell: Cornell University Press, 1998, p. 179.
- ³⁵⁷ Dworkin G. *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press, 1988.
- ³⁵⁸ O'Neill N. *Autonomy and Trust in Bioethics*. Cambridge: Cambridge University Press, 2002. p. 44-48.
- ³⁵⁹ Mill JS. On Liberty. In: Gray J (ed.). *On Liberty and Other Essays*. Oxford: Oxford University Press, 1991. p. 17
- ³⁶⁰ Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. (4th ed.) Oxford: Oxford University Press, 1994. p. 72
- ³⁶¹ Gauthier D. 1986. *Morals by Agreement*, Oxford: Clarendon Press. 1999.
- ³⁶² Both are possible interpretations of Kant's categorical imperative, see Kant, I 1998, *Groundworks of the Metaphysics of Morals*, Cambridge: Cambridge University Press.
- ³⁶³ Rawls J. *A Theory of Justice*, Oxford: Oxford University Press. 1972.

-
- ³⁶⁴ Taylor C. *The Ethics of Authenticity*, Cambridge, Mass.: Harvard University Press. 1992.
- ³⁶⁵ Waltzer, M 1985, *Spheres of Justice: A Defence of Pluralism and Equality*, Oxford: Basil Blackwell.
- ³⁶⁶ McIntyre, A 1985, *After Virtue*, London: Duckworth.
- ³⁶⁷ Baier, K 1958, *The Moral Point of View*, Ithaca, N.Y.: Cornell University Press.
- ³⁶⁸ Dawson, A. & Verweij, M. 2006 (eds.) *Ethics, Prevention, and Public Health*. Oxford: Oxford University Press.
- ³⁶⁹ Verweij, M. & Dawson, A. 2006, The Meaning of 'Public' in 'Public Health', in Dawson, A. & Verweij, M. 2006 (eds.) *Ethics, Prevention, and Public Health*. Oxford: Oxford University Press.
- ³⁷⁰ Murray, CJL et al (2002) *Summary Measures of Population Health: Concepts, Ethics, Measurement and Applications*. WHO: Geneva.
- ³⁷¹ *An Introduction to the Swedish National Institute of Public Health*, Stockholm: Swedish National Institute of Public Health. Internet access: http://www.fhi.se/upload/ar2005/ovrigt/PublicHealthPolicy_0505.pdf